BARRIERS AND VALUES OF MORAL DISTRESS

AMONG CRITICAL CARE NURSES

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by

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The undersigned, appointed by the dean of the Graduate School, have examined

the dissertation entitled:

BARRIERS AND VALUES OF MORAL DISTRESS

AMONG CRITICAL CARE NURSES

presented by Melissa A. Wilson, a candidate for the degree of doctor of

philosophy, and hereby certify that, in their opinion, it is worthy of acceptance.

Dr. Gregory Alexander
Dr. Deborah Finfgeld-Connett
Dr. Lori Popejoy
Dr. Win Phillips

DEDICATION

       This work is dedicated to my family. There are no words that could express the depth of gratitude that I have for my husband, children, parents, and friends. Never could this success and achievement have been attained by my own strength. To be a wife, a nurse, a mom to two active preteen and teenaged children, a daughter to parents that in the past few years also needed a nurse, a servant called to minister to those that don't know God or are searching for a deeper relationship with Him, a sister, a stepmom and step-grandma, a friend, work full-time and achieve my goal of a PhD in nursing; it took the amazing power of God and faith to live beyond my natural ability to be successful in all these things and make this achievement possible.   My husband Ron worked tirelessly to ensure that I always had time to study or write, gave me a semi-quiet home to think in, a peace of mind that my children had the best dad taking care of them when I was 'working' and an exorbitant amount of love and support to fulfill my educational dreams.   My children, Olivia and Ovid gave me the desire to want to be my best and to work hard every day at trying to be worthy of being called 'mom' by these incredible kids. My mom and dad, Harold and Mary who inspired me from an early age to strive for what is hard and to always put myself in a position I was not comfortable in so that I knew I was growing and evolving into a better human-being. To my special friends that have loved me along the way. Thank you for the listening ears, calls, text, cards, weekends away, pats on the back and prayers for me. All of you gave me the inspiration and encouragement to carry-on when I thought I could not push further in this endeavor.

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Right now as I finish this unyielding effort in my life, it's difficult to say I

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Melissa Wilson

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ABSTRACT

This dissertation explores the presence of moral distress and effective interventions to lessen its impact on critical care nurses. Manuscript one was completed prior to entering the doctor of philosophy in nursing program but was instrumental in building the foundation for successive work within this dissertation. An exploratory, descriptive designed study was used to examine moral distress and identify situations in which nurse's experienced high levels of moral distress. Nurses completed a 38-item moral distress scale, a coping questionnaire, and indicated their preferred methods for institutional support in managing distressing situations. Manuscript two includes a formal analysis of the Moral Distress Theory and identified limitations in the existing theoretical model based on a review of literature. Finally, manuscript three is a study identifying barriers and values during moral distress situations that can be used to potentially target interventions aimed at lessening the impact of moral distress.

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CHAPTER ONE

General Introduction

Moral distress is ever-present in health care. From birth to death, registered nurses are integral to most health care encounters (Joint Commission of Accreditation of Hospital Organizations [JCAHO], 2002). With over 2.5 million deaths occurring each year globally (Murphy, Kochanek, Xu, & Arias, 2015), nurses are likely to experience situations in which a moral disequilibrium is present while caring for these dying individuals or while caring for others during healthcare encounters. In healthcare, this imbalance between the caregivers' own moral values and the moral beliefs occurring within the situation can lead to what is called moral distress.

This phenomenon was first described in the 1980's and continues to impact nurse's satisfaction, retention, and recruitment and has implications for the safe delivery of patient care (Pauly, Varcoe, & Storch, 2012). There is an irrefutable link between healthy work environments, patient safety, nurse recruitment, and nurse retention (AACN, 2001). An estimated 880,000 nurses in the US or one in three nurses experience moral distress which contributes to their decision to change departments within a facility, leave an organization or to quit professional practice as a nurse (Bureau of Labor Statistics, 2013; Millette, 1994; Redman & Fry, 2000; Wilson, Goettemoeller, Bevan, & McCord, 2013). Nurses experiencing moral distress often distance themselves from patients, lose the capacity to care, fail to give good physical care, communicate poorly with

coworkers, suffer emotional distress, and experience symptoms of burnout (AACN, 2008; Epstein & Hamric, 2009). Nurses who choose to remain at an institution and who suffer with unresolved moral distress can perpetuate decreased quality of patient care, increased costs and poor patient satisfaction (Cimiotti, Aiken, Sloane, & Wu, 2012; Epstein & Hamric, 2009). This issue is so great that the AACN has issued a policy position that every nurse and every employer of nurses is responsible for implementing programs and mitigating the effects of moral distress (AACN, 2008).

Moral and ethical situations are likely to occur throughout a nurses' daily practice. In particular, nurses working in critical care environments often encounter patient care which includes high stakes life and death situations. For instance, moral distress has been studied extensively in intensive care environments due to the frequency of highly complex patients and use of advanced technology to sustain life (Corley, 1995; Cronqvist, Lutzen, & Nystrom, 2006; Elpern, Covert, & Kleinpell, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Wilson et al., 2013). Advancing technologies have enabled intensive care nurses to participate in sustaining life beyond what was possible in the past and sometimes beyond what they personally feel is in the best interest of the patient.

Moral distress can lead to suffering and result in an unhealthy work environment (AACN, 2001; Rushton, 2006). Interventions to reduce or eliminate the effects of moral distress have been limited due to the complexity of the situations and the various effects of moral distress on people and organizations.

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The nurses' recognition and impact of moral distress varies with the multitude of situations that cause moral distress. The topic of moral distress has been studied frequently in the past few decades (Lutzen & Kvist, 2012); however, interventions for moral distress are less studied. Assessment and interventions to lessen the impact of moral distress have been particularly challenging due to the subjective and personal nature of the experience of moral distress.

This dissertation project is important because it explores the science of this phenomenon to understand it better at a fundamental level so that researchers may begin to address interventions and lessen its impact on nurses, patients and healthcare organizations. The purpose of this research is to 1) examine the current state of theoretical constructs in the area of moral distress 2) determine how the theoretical constructs connect to the current state of the science, and 3) identify current values and barriers in moral distress experiences. This research will provide crucial evidence to move this area of science forward by identifying specific constructs of moral distress that can be used in future intervention work. Findings from this research may be used to inform future primary studies.

Chapter 2 is a manuscript from a study entitled "Moral distress: levels, coping and preferred interventions in critical care and transitional care nurses". This study was completed prior to my doctoral studies and published during the matriculated portion of my doctoral program. This study examined the frequency and intensity of moral distress in two types of high acuity units and evaluated the likelihood of utilizing resources for moral distress. Despite having relatively low levels of moral distress measured on a well-established quantitative scale, nurses

from both units described fairly intense stories in their open-ended responses (Wilson et al., 2013). Sixty-two percent of nurses in this study reported distressing situations having a 'definite' to 'somewhat' impact on their personal coping strategies and 73% reported their work performance was impacted (Wilson et al., 2013). Nurses gave examples of how moral distress situations impacted them and the themes were in the areas of 'internalizing care', 'workload and support', 'futile care', 'organizational and/or legal', and 'interprofessional collaboration' (Wilson et al., 2013). This led the researchers to question the incongruence in the quantified responses to moral distress from their description of the events. Previous studies have supported that nurses have difficulty naming the experience of moral distress (Gutierrez, 2005; Hanna, 2004). It was the authors' recommendations that identifying the particular trigger in a nurse, may help to exploit the situation of moral distress thereby targeting interventions towards awareness from the start of the situation (Wilson et al., 2013). Additional work on the open-ended responses from this study was completed by the lead author. In an unpublished Institutional Review Board approved secondary analysis of this data, the 'impact on the organization' was the most frequently occurring theme when describing moral distress situations (Wilson, 2015). Additionally, values expressed in these open-ended responses were coded according to the American Nurses Association recently updated *Code of Ethics* (2015) and the provision of 'duty and loyalty' was the area that nurses expressed was violated most during these situations of moral distress (Wilson, 2015). Focusing interventions on the organization's role in moral distress and promoting

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a nurses' ability to act in accordance to their value of duty and loyalty may provide a direction for effective moral distress interventional studies in the future.

The subsequent chapters of this dissertation (Chapters 3 & 4) stem from the questions that arose in this previous research and are linked to the overall dissertation project. Chapter 3 is a formal theory analysis and evaluation of the Moral Distress Theory (MDT) (Corley, 2002). This includes an exhaustive literature review of moral distress and analysis of the theory commonly used to explain this phenomenon. From this work, a nurses' personal and professional values were identified as quintessential to the development of moral distress but these value systems were not evident in the MDT. In addition, completed research since the inception of the MDT has further explored its meaning and understanding which seems to indicate that this theory may no longer be representative of the current state of the science of moral distress.

This discovery lead to chapter 4, a manuscript describing a qualitative study aimed at exploring barriers and values described by nurses who have experienced moral distress in their job by utilizing a descriptive qualitative methodology. Interviews with seven critical care nurses who reported moral distress experiences was completed. A content analysis was performed on these stories to identify the barriers and values present in moral distress patient care experiences. These stories will help to further the understanding of the experience and will be used to identify specific targeted interventions to lessen the impact of moral distress on nurse clinicians in future studies.

Chapter 5 concludes the dissertation document, synthesizes the overall

project and outlines other current work by the researcher that is taking place in the area of moral distress.

CHAPTER TWO

MORAL DISTRESS: LEVELS, COPING, AND PREFERRED INTERVENTIONS IN CRITICAL CARE AND TRANSITIONAL CARE NURSES

Abstract

Aims and objectives. To examine the level and frequency of moral distress in staff nurses working in two types of units in an acute care hospital and to gather information for future interventions addressing moral distress. **Background**. In 2008, the American Association of Critical Care Nurses published a *Position Statement on Moral Distress.* Nurses working in units where critically ill patients are admitted may encounter distressing situations. Moral distress is the painful feelings and/or psychological disequilibrium that may occur when taking care of patients. **Design**. An exploratory, descriptive design study was used to identify the type and frequency of moral distress experienced by nurses. The setting was an acute care hospital in which the subjects were sampled

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from two groups of nurses based on their unit assignment.

Methods. A descriptive, questionnaire study was used. Nurses completed the 38-item moral distress scale, a coping questionnaire, and indicated their preferred methods for institutional support in managing distressing situations. A convenience sample of staff nurses was approached to complete the moral distress questionnaire. **Results**. Overall, the nurses reported low levels of moral distress. Situations creating the highest levels of moral distress were those related to futile care. A significance between group differences was found in the physician practice dimension. Specific resources were identified to help guide future interventions to recognize and manage moral distress. **Conclusion**. Nurses reported lower levels and frequency of moral distress in these units but their open-ended responses appeared to indicate moral distress. Nurses identified specific resources that they would find helpful to alleviate moral distress. **Relevance to clinical practice**. There are numerous studies that identify the situations and the impact of moral distress, but not many studies explore treatments and interventions for moral distress. This study attempted to identify nurse preferences for lessening the impact of moral distress.

Working in the acute care hospital setting can lend itself to an environment that results in nurses being presented with difficult and challenging situations. These situations are such that if encountered on a daily basis could result in a painful, psychological disequilibrium. Since the 1980's this disequilibrium in nursing practice has been named moral distress and studied extensively in intensive care units. Less research has evaluated nurses coping to situations that precipitate moral distress. In addition, there is limited information for the best interventions to guide organizational practice to address and limit the occurrences of moral distress.

Nurses working in Intensive Care Units (ICU) and units where acutely ill and chronic long term patients are frequently admitted, such as a Transitional Care Unit (TCU), may encounter moral and ethical issues related to human life experiences of suffering and death. The philosopher Jameton (1984) defined moral distress as "painful feelings and/or psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory support, exercise of medical power, institutional policy, or legal limits" (Jameton, 1984; Jameton, 1993; Corley, 2002, p. 636-637).

Background

Moral distress has been studied extensively in the intensive care environment. These environments contain a frequency of highly complex patients and challenging situations that involve the use of advanced technology (Corley,

1995; Cronqvist & Nystrom, 2004; Elpern, Covert, & Kleinpell, 2005; Hamric & Blackwell, 2007; Mobley, Rady, Verheijde, Patel & Larson, 2007; McClendon & Buckner, 2007). The critical care environment often involves situations that call for a nurse to overcome institutional obstacles and interpersonal conflicts about values. While patient technology has advanced, it has also given health care workers the ability to sustain physical life well beyond what was possible in the past.

Futile care can be described as life-sustaining interventions or treatments that are implemented without regard to the overall outcome benefit to the patient (Meltzer & Huckabay, 2004). These interventions are generally instituted because of family or patient desire. Often this is done without the family having adequate medical knowledge or the inability of the profession to explain the process of withdrawal of care. The determination of medical futility can only be made within the context of the individual clinical situation. In a study by Elpern, et al. (2005), the highest levels of moral distress were found in situations where aggressive care was given to terminal patients. Withdrawing, halting, or continuing interventions that prolong life or delay the inevitable death can be difficult for all members of the health care team to experience. This results in an experience that may include moral distress by the nurse.

In addition to futile care, other situations that can create moral distress include those involving the nurses' internal and external barriers which may be out of their control. Internal barriers are characterized as a lack of awareness,

lack of confidence, insufficient clinical skills, or fear of taking action when morally distressing events occur (AACN, 2008a). External barriers may be such things as lack of time, lack of administrative support, feeling of inequality of power, in-house politics, legal constraints, staffing shortages and communication barriers between physicians, families, patients and nurses (Gutierrez, 2005; AACN, 2008). In a study by Pauly, Varcoe, Storch, & Newton (2009), external situations that caused the highest degree of moral distress were staffing issues and perceived physician incompetence. All types of barriers create vulnerability in the nurse that can potentiate a distressing experience.

Moral distress is a phenomenon that can occur whether known to the nurse or not. Because of the very nature of moral distress, nurses may or may not be able to name the experience. Redman and Fry (2000) stated that one out of three nurses report experiencing moral distress. Moral distress may appear as a nurse distancing themselves from a patient, losing their capacity to care, failing to give good physical care, poor communications with coworkers, suffering emotional distress and experiencing symptoms of burnout (AACN, 2008). In a study by Solomon, O'Donnell, Jennings, and Guilfoy (1993), 50% of the nurses stated they acted against their own consciences in providing care and that this caused them distress. Naming the event or describing it as an act against a persons' conscience is the root of moral distress and can begin to weigh heavily on nurses as they participate in the act of caring.

Nurses can experience moral distress in a variety of clinical settings and

with a variety of patient types. Moral distress has been reported among nurses

working in units where end of life and appropriateness of care decisions are made

throughout the practice of care delivery (Hamrick & Blackhall, 2007). Critical

care and specialty-type units are areas that typically encounter situations leading

to moral distress.

The AACN concluded that a healthy work environment can lead to

positive patient outcomes and nurse satisfaction (AACN, 2001). Conversely,

unhealthy work environments play a role in errors, ineffective care, and moral

distress (AACN, 2001). Identifying and implementing interventions to improve

moral distress can lend itself to improvements in the overall health care

environment. When nurses experience moral distress, they may begin to withdraw

from the work environment, lose their capacity to care and fail to provide

thorough care to the patient and family. Moral distress can lead to suffering

(Rushton, 2006) and result in an unhealthy work environment (AACN, 2008).

Advances in health care technology and the ability to sustain life in non-

functioning individuals are situations that increase the prevalence of moral

distress. Compounding these issues are the frequent staffing and institutional

barriers that exist within health care either at the local or global level. Moral

distress is common and can result in nurse job dissatisfaction, burnout,

resignation, and/or distancing oneself from patients and families (Meltzer &

Huckaby, 2004; McClendon & Buckner, 2007; Rice, Rady, Hamrick, Verheijde,

& Pendergas, 2008). With the proper interventions, the frequency of moral

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distress may be limited; thus resulting in increased job satisfaction and improved patient and family relations (AACN, 2008a).

In 2008, AACN published a *Position Statement on Moral Distress* calling it a "frequently ignored problem in healthcare environments" (AACN, 2008a, p.1).   The call to action for nurses is to recognize and name the experience of moral distress, and to commit to using professional and institutional resources to address it. The call to action for employers is to monitor the clinical and organizational climate for recurring situations that contribute to moral distress and to create support systems that will aid in its relief (AACN, 2008a). "The importance of identifying and taking steps to address moral distress among critical care professionals cannot be overstated" (Morris & Dracup, 2008, p. 400).

This pilot study evaluated the level and frequency of moral distress in critical care nurses and explored preferred interventions to reduce the impact of moral distress. Therefore, the purpose of this study was twofold: 1) to examine the level and frequency of moral distress in staff nurses working in two units in the critical care division of one hospital, and 2) to gather information to potentially guide future support, resources and interventions for moral distress in staff nurses. The research questions were:

○ What is the level and frequency of moral distress in staff nurses who work in intensive care and a transitional care units?

○   Is there a difference in the level and frequency of moral distress between these two types of units?

○ Is there is a difference in the type of situations that result in a high level of moral distress among nurses that work in these units?

○ Does the level of moral distress vary with individual characteristics or demographics?

○ How likely are these nurses to utilize various resources for moral distress?

Methods

Design

An exploratory, descriptive design study was used to identify the type and frequency of moral distress experienced by nurses who are exposed to specific patient care situations. The setting was an acute care hospital in which the subjects were sampled from two groups of nurses based on their unit assignment in the Medical-Surgical Intensive Care Unit (MSICU) or the Transitional Care Unit (TCU).   A convenience sample of 105 staff nurses (81 from the MSICU and 24 from TCU) in a suburban Midwestern hospital were approached to complete the moral distress questionnaire. All current full or part time RNs employed by the hospital who worked on one of the units for a minimum of the previous six months were invited. Nurses currently on family or medical leave of absence were excluded.

Ethical Considerations

The study proposal was reviewed and accepted by the hospital's institutional review board. Unit managers provided a list of nurses meeting

eligibility criteria for the study. A cover letter, the questionnaire, and a

demographics sheet were distributed and returned in a sealed envelope to a secure

locked box. To maintain anonymity, questionnaires were color-coded so that

responses from nurses working on the two units could be recorded separately. On

the day of distribution, an email was sent to all eligible nurses inviting them to

participate in the study. A short explanation of the purpose for the study was

included in the email. Two of the authors maintained the keys to the secure locked

boxes. Two weeks after the questionnaires were distributed, a reminder email

was sent to all eligible participants. Participants placed completed questionnaires

in the provided sealed envelope and dropped them in a secure locked box located

on each unit.

Instruments

Data collection occurred over a four week period. All returned

questionnaires were assigned a code upon retrieval from the locked box in order

to analyze open-ended responses in part two of the questionnaire to the responses

in part one of the questionnaire, then entered into the Statistical Package for the

Social Sciences (SPSS). Subjects were asked to complete the revised Moral

Distress Scale (MDS) which consisted of a 38-item questionnaire revised,

developed and tested by Dr. Mary Corley and colleagues.

The original MDS was developed by Dr. Corley and colleagues

and published in 2001 (Corley, Elswick, Gorman & Clor, 2001), while the revised

MDS published in 2005 was developed to include additional ethical concerns

(Corley, Minick, Elswick & Jacobs, 2005). One study published in 2007, noted that the tool was adapted to a shortened version of 19 items for use with both RN and physician participants (Hamric & Blackhall, 2007). Email permission to use both versions was obtained from Dr. Corley by the authors. The revised MDS was chosen for this study based on its ability to answer the study questions by measuring both the intensity and frequency of moral distress. The opening paragraph of the shortened version was used as the heading for the revised MDS due to its succinctness and clarity in describing the phenomenon under study to participants. There are six dimensions of practice area that are covered in the MDS tool: 1) physician practice, 2) nursing practice, 3) institutional factors, 4) futile care, 5) deception, 6) euthanasia.

The revised MDS has a content validity index of 100% and Cronbach's alpha of 0.98 for the intensity scale and 0.90 for the frequency scale (Corley et al., 2005). The Cronbach α for the shortened MDS was reported at 0.83, measured by using a product score for each item (Hamric, & Blackwell, 2007). Some version of the MDS has been used in at least five previous studies (Corley, 1995, Corley et al., 2005; Elpern et al., 2005; Hamric & Blackwell, 2007, Zuzelo 2007; Pauley et al., 2009).

The study participants completed a paper and pencil questionnaire consisting of three parts: Corley's Revised MDS Questionnaire (used to collect data on moral distress), the Coping Strategies and Resource Questionnaire, and the demographics and background information form. The latter two parts were

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developed by the authors. The Revised MDS was included to evaluate the existence and degree of moral distress on these units. Coping strategies and resources were evaluated to determine what measures nurses currently used or would like to utilize to manage distressing situations. The third part was included to examine if demographic variables influence moral distress and coping.

The Coping Strategies and Resource Questionnaire consisted of four questions; two open-ended and two forced-answer questions. The first question was adapted from Corley (2005), while questions two, three, and four were developed by the authors. The purpose of the questions in part 2 was to determine how nurses rated themselves on the following questions a) have you ever left or considered leaving a position, b) rate the impact on your coping strategies, c) rate the impact on your life, d) how likely are they to utilize resources that are/ or would be provided. They were given a scale to rate themselves of **0-** not impacted, **1**- slight, **2**-somewhat impacted, **3**- definitely impacted. Additionally, there were areas where the staff could write free text about specific experiences related to the questions. The resources specified were adapted from the AACN Position Statement (2008).

Part 3 included demographic data questions developed from a review of literature of previous moral distress studies.

Data Collection

The first part of the questionnaire was the revised MDS Scale data collection tool. The questions were subdivided into six different categories which

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the authors of this study refer to as "dimensions": physician practice (items 4, 6, 7, 10, 11, 15, 17, 18, 23, 25, 26, and 35), nursing practice (items 8, 9, 13, 16, 32-34, 36-38), institutional factors (items 14, 20, 21, and 27), futile care (items 1, 2, 3, 5,12,19, and 22), deception (items 24, 30, and 31) and euthanasia (items 28 and 29). Scoring of the moral distress scale was done consistent with procedures outlined in a previous study by Hamric and Blackwell (2007). Subjects rated both the frequency and intensity of situations that could engender moral distress on a scale from 0 (never occurred/not disturbing) to 4 (occurred very frequently/greatly disturbing). The frequency score and intensity score were multiplied so that items that were rarely experienced or were not distressing had low scores. Each item product of frequency and intensity ranged from 0 to 16. To obtain a composite score of moral distress, the products of the 38 items were added together. This method allowed all items marked as never experienced or not distressing to be eliminated from the score. Each dimension range varied according to the number of questions within that dimension.

Descriptive statistics were used to display the presence, amount, and type of distress experienced among both groups of nurses. The t-test for independent groups was used to compare the level of moral distress in MICU and TCU nurses. One-way ANOVA was used to determine differences in types of situations that result in a high level of moral distress among nurses that work in MSICU and TCU. The Bonferroni post-hoc test was used to test differences in the level of moral distress with individual characteristics or demographics.

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Frequencies were examined in the scale from data in the Coping Strategies and Resource Questionnaire, and free text was examined by all authors for content and themes. Cronbach α was done on the questionnaire to determine the reliability for this population and was reported as 0.90.

Results

A total of 105 questionnaires were distributed with 61 returned for a return rate of 58%. Of the 61 returned surveys, 11 were excluded after collection from data analysis due to missing data (i.e. entire portion of either part 1, 2, or 3 not completed), resulting in a total N=50. The reported N used for each of the six dimensions of moral distress under study ranged from 44-50. The N for each dimension was determined by including surveys that had all questions in that dimension completed.

Participants consisted of 45 women and 3 men and 2 unknown due to not completing this response. Ages ranged from 21 to over 61 with the highest percent between 41-50 (33%). Bachelor prepared nurses constituted 52% of the participants while 19% held certification in various areas of nursing. In the MSICU, 33% had worked 3-5 years. In the TCU, 78% worked 0-2 years. Table 1 provides details about the demographics.

The mean scores for level and frequency of moral distress among nurses working in the MSICU and TCU were 119.3 (range 10-253; SD 62.3) and 117.5 (range 17-243; SD 60.5), respectively. This result signifies an overall mean moral distress rating of "none-slight" using the following scale: 0-154 (none-

slight), 154- 304 (mild), 304- 458 (moderate), 459-608 (severe). This scale was created by the authors to equate the total product scores multiplied by the 38 questions on the moral distress scale for a scale ranging from 0-608. Based on these quartiles, both the mean levels of moral distress were rated as "none to slight". Utilizing a *t*-test, there was no statistically significant difference between the mean levels of moral distress between MSICU and TCU ($f= 0.57$; $P=<.05$).

When evaluating if the level of moral distress varied with individual characteristics or demographics, the Bonferroni post-hoc test indicated there were no significant differences in findings related to the categories of "Years RN", "Age", "Education", "Certification", "Years MSICU" and "Years in TCU" that were significant in the six dimensions ($P<.05$). The only category that was approaching significance was the demographic of "years as RN" and the dimension of "euthanasia" ($r= .077$, $P=<.05$).

When examining differences in the type of situation that resulted in a high level of moral distress based upon what unit the nurse worked, the only dimension that showed a significant difference between the two groups was physician practice ($p= .038$, $P=<.05$) utilizing a one-way ANOVA. Although all responses were in the "none to slight" range, none of the other dimensions showed a statistically significant difference (see Table 2). Within the physician practice dimension, there are two statements that rated as significantly different depending on which unit the nurse worked: "assist a physician who performs a test or treatment without informed consent" ($p= .020$, $P=<.05$), and "assist a

physician who in your opinion is providing incompetent care" (p= .015, *P*=<.05).

Approaching significance was the statement "ignore situations of suspected

patient abuse by caregivers" (p= .084, *P*=<.05).

As with the demographic mean scores, the authors developed a

severity subscale to quantify the dimension scores for each unit. The total possible

score for each dimension was divided into four levels of severity: none-slight,

mild, moderate, and severe. Each dimension had its own total based upon the

differing number of questions within that dimension (Refer to Table 2).

To evaluate the research question of "How likely are these nurses to

utilize various resources for moral distress?", participants were given a list of the

following resources to choose from: a) ethics committee work, b) individual

counseling, c) online education, d) protocols for end of life, e) debriefing sessions,

f) pamphlet development, g) forums, h) Employee Assistance Programs, or i)

workshops. The top two categories of responses for "very likely to" or "maybe"

will utilize these resources were ethics committee at 79% and debriefing at 78%.

In response to the question "Have you ever left or considered leaving a position"

on the Coping Strategies Questionnaire, 18% from MSICU and 6% from TCU

stated they left a position due to a distressing situation. 21% from MSICU have

considered leaving, 59% of TCU have considered leaving (Figure 1). When asked

about the impact on "coping strategies", 27% of combined units said that their

coping strategies have definitely been impacted and 35% said somewhat impacted

for a combined impact of 62% (Figure 2). Impact on personal life--combined

units said that 49% of the time they have been definitely or somewhat impacted by these work situations (Figure 3). 73% of respondents reported that their work performance was impacted in some way (Figure 4).

Respondents were also asked to provide examples of how they had been impacted by distressing situations. Of the 50 surveys analyzed, 26 respondents provided responses that ranged from a few words to several sentences. All authors analyzed the open-ended comments and categorized them into themes. If discrepancies were noted, the authors discussed the specific responses and were in agreement with the identified themes. Themes identified were: internalizing care, workload and support, futile care, organizational and/or legal concerns, and interprofessional collaboration. The following is a representative sample of responses within the themes identified.

Internalizing Care

"Just taking care of certain patients who remind me of a family member who passed or dealing with a similar health problem can make me feel impacted. I sometimes think about patients when leaving the hospital or long after discharge, the ones who touch my heart**.**"

"My personal life is impacted when I go home and I think about my patients."

"My work performance has gotten worse due to this situation- my home life is affected due to support received from home and also I am feeling exhausted."

"It affects my goals/standards in patient care- feel like they were not met."

"Difficulty sleeping, unable to give adequate care."

"I feel burnout in my position."

Workload and Support

"My work performance is impacted when I feel like I am being pulled in many directions.

"I feel like I have become less empathetic and careless due to workload"

"No helper available when I was busy- I felt so much stress and so behind in care."

"I was not supported or in situations that were uncomfortable. I feel that my coping and work performance became stressed and I didn't work as efficiently or effectively."

"I couldn't fathom taking another patient when one of my patients was so time consuming and ill."

"At this job-I feel like more is expected out of me for no more pay."

Futile Care

"It has become very difficult to care for patients who I know will never get better and have no quality of life – i.e. - our chronic vent patients."

"I feel that the lack of quality of care and unnecessary treatments /futile care happens more often than it should."

Organizational and/or Legal

"Fear of legal action has placed me in several positions that have made me take care of a patient in a manner that I believe was incorrect."

"I feel that having a full time physician could help greatly reduce futile treatment and increase the quality of care."

"I sometimes feel pressured to move patients to other units for "number/census"

Interprofessional Collaboration

"There are frequently situations that MD's do not respect the views of bedside nurses- these situations have caused me to reevaluate my role in the hospital."

"It is morally distressing when patients are not receiving high quality and beneficial care."

"I had a situation when two doctors did not agree with my clinical assessment and dismissed my concerns when a patient change in status was noticed. I was not supported by my doctors and felt belittle and ignorant."

Discussion

Both the TCU and MSICU nurses rated themselves as having an overall low frequency and low intensity of moral distress. When evaluating the six dimensions of moral distress, the dimension related to "physician practice" was significantly higher among the nurses working in the MSICU. Other studies

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found similar results related to high intensity of moral distress in the physician practice domain (Rice et al., 2007; Mobley et al., 2007; Pauly et al., 2009). In the MSICU, the potential to have frequent and critical situations that directly involve physicians and nurses could account for the difference in the MSICU group versus the TCU group. Questions within the physician practice dimension with the highest significant difference were "assist a physician who performs a test or treatment without informed consent (f=.02, P=<.05) and "assist a physician who in your opinion is providing incompetent care" (f=.015, P=<.05). Hamric and Blackwell (2007) concluded that attention must be paid to how we build and maintain interprofessional relationships to improve the ethical environment. Fostering the nurse-physician relationship can decrease the level of moral distress experienced (Oberle & Hughes, 2001). As we expand resources and interventions to build interprofessional relationships, perceptions of distressing situations may improve with improved team member relations.

Futile care in both groups had the highest level and frequency of distressing events. Perception of futile care is likely to be generated from two main sources: inability to relieve suffering or provide adequate pain control and utilizing extensive medical resources on a patient that is unlikely to survive (Curtis & Burt, 2003). The ever-increasing number of complex patient care situations in these environments contributes to the experiences of futility. As with previous studies, the findings indicate that care that is perceived as futile contributes to the highest level of moral distress among the nurses (Meltzer &

Huckabay, 2004; Elpern et al., 2005; Mobley et al., 2007; McCleadon & Buckner 2007; Rice et al., 2008). By the very nature of the patient's in these units, the perception of futile care is likely. Interventions may be best directed to help alleviate the strain of futile care rather than strategies to prevent the distress of futile care altogether.

The second part of the questionnaire explored coping strategies. Of the combined participants, 24% percent (18% from the MSICU group and 6% from the TCU group) indicated they have left a position because of their discomfort with the way care was handled in their assigned unit. Of the combined participants, 80% (21% from the MSICU group and 59% from the TCU group) indicated that they have considered quitting. Findings from similar studies reveal that nurses leave positions due to moral distress (Millette, 1994; Corley et al., 2001). The number of nurses in the MSICU that reported actually leaving a position due to this discomfort may be related to the increased years of experience in that particular type of unit that the MSICU nurses had over the TCU nurses in this study. A higher number of TCU nurses have considered leaving their position but had not at the time of the questionnaire. The authors are not clear as to an explanation for this finding. It may be in part to the chronicity of the clientele and a sense of responsibility felt by the nurses in caring for these frequently encountered patients' as seen in TCU-type units.

Even though both groups of nurses rated themselves as having a fairly low moral distress score overall, their open-ended comments described the impact to

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their personal and professional lives. Predominant themes in both groups of nurses were identified as the nurses' internal awareness of distress, workload and unit support, their perception of care that is unnecessary or likely to not produce an optimal outcome, lack of organizational support and/or fear of legal repercussion, and relationships with other team members. The chronic long term unit that participated in this study is a smaller unit with less staff and support personnel, less physician interaction, and more heavily acute chronic type of patients, which may account for the feelings reported. Comparatively, the critical care environment is larger with more unit and staff support but nurses tend to be isolated while caring for the critically ill patient. Physician interaction is increased in the MSICU, but may not necessarily be perceived as a collaboration or relationship building interactions.

Coping strategies and effects of personal lives were examined in the open-ended portion of the questionnaire. 62% of the respondents reported distressing situations as having "definite" to "somewhat" impact on their coping strategies and 49% reported as having "definite" to "somewhat" impact on their personal lives. Previous studies have reported nurses descriptions of the impactful effects of moral distress and describe them as being depressed, sleeplessness, emotional distress, feelings of anguish, tearful, a sense of isolation, physical symptoms such as nausea, gastrointestinal upset and migraine headaches (Hanna, 2004; Ruggiero, 2005). Even though the overall level and frequency of moral distress reported on the MDS was low, nurses in this study did recognize that distressing situations

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impacted their coping strategies and personal lives.

Incongruent responses were obtained between how nurses quantified moral distress and described moral distressing events. The authors believe that the nurses who participated may have difficulty personalizing a generalized self-examination scale over the opportunity to explore individualized experiences. Previous research has demonstrated that nurses have a difficult time naming and equating what is affecting them (Hanna, 2004; Gutierrez, 2005). Future research needs to explore methods to identify and quantify moral distress on an ongoing basis. Moral distress will always be a part of caring for people in a health care setting but it is possible to develop a new way of acknowledging and responding to this distress (Rushton, 2006).

Recommendations for Practice

Interventions may need to be geared at helping nurses articulate the feelings of moral distress, which at its essence, is the dilemma that moral distress embodies. Jameton defined moral distress as knowing the right action but the inability to act on it, thus causing this internal conflict (Jameton, 1984). Morris and Dracup (2008) note that the frequency of situations causing moral distress in the ICU environment will likely increase. A clinical measurement tool that is able to quickly identify escalating moral distress is needed that accurately measures moral distress in a given work environment. Such a tool can be used to measure the potential threat to staff and guide interventions appropriately (Dracup & Morris, 2008).

Moral distress has consequences including stress, burnout, job dissatisfaction, departure from profession and/or organization, burnout, and/or distancing oneself from patients and families (Meltzer & Huckaby, 2004; McClendon & Buckner, 2007; Rice et al., 2008). It affects the "quality, quantity, and cost of nursing care" (AACN, 2008a, p. 1). The effects of moral distress are so widespread that the interventions should be directed to all aspects of the organization. A cross-organization approach is recommended that encompasses interventions within all realms of the patient care environment (AACN, 2008a). Less staff turnover resulting from higher levels of staff satisfaction can be effect brought on by facilities that recognize and respond to the experience of moral distress (Pendry, 2007). Resources should also be available to nurses that seek assistance with the impact of moral distress on their personal lives. When asked what resources nurses would utilize to cope with distressing circumstances, the two most frequently selected were ethics committee and debriefing. Once recognition of a distressing situation occurs, participants indicated that a collective approach to addressing the situation should occur. A collaborative, interprofessional, respectful environment is one that creates an environment for addressing morally distressing situations (AACN, 2008a). Ethics rounds, discussion groups, and debriefing sessions may provide an opportunity to recognize and collaboratively contribute to discussions about experiences within the unit (Zuzelo, 2007). Regular rounding may facilitate early recognition and resources to implement interventions to lessen the impact of moral distress.

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Meltzer and Huckabay (2004) suggest charge nurses and/or a counselor be available on patient units for regular rounding and discussions related to morally the availability of an ethics committee 24 hours a day.

Limitations

There are limitations of this research study. This was a single-site study with unique institutional factors and physician practice patterns. The sample size was small with demographics that may not be representative of other nurses. Individual personal experiences could have impacted the results that were not examined. The method used for scoring moral distress could have underestimated the amount of moral distress present.

Not all surveys that were returned had complete data in all three sections of the questionnaire. This may have been related to the length of the survey or the generation of uncomfortable feelings due to the sensitive topic under study.

Conclusion

In 2008, the AACN released a charge to all nurses and health care employers to recognize and implement interventions that lessen the effects of moral distress. Critical care nurses and nurses that care for acute and chronically ill clients report moral distress. The highest levels of moral distress were within the physician practice and futile care dimension. Interprofessional relationships and care that is perceived as unnecessary appears to have the most effect on perceptions of moral distress. The nurses in this study rated themselves as low but are able to describe distressing events that impacted their professional and

personal lives. A high percentage of the nurses surveyed reported having left or considered leaving a position because of these distressing situations. Preferred interventions to address moral distress were group-type discussions and ethical rounding.

Moral distress is a serious issue that affects all areas of the health care organization. Future research needs to develop an easy-to-implement, quick, ongoing tool for recognizing moral distress early and processes to implement interventions. Recognizing events that precipitate moral distress and early interventions for managing moral distress are keys to limiting its effects. Further studies are needed to evaluate the specific interventions suggested by nurses in this study and evaluate their ability to reduce and/or eliminate the effects of moral distress.

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Table 2.1

Participant Demographics

Characteristic	N	%
Gender		
Male	3	6
Female	45	94
Total	48	100
Age		
20-30	15	31
31-40	10	21
41-50	16	33
51-60	4	8
61 and up	3	6
Total	48	100
Education		
Diploma	5	10
Associate	16	33
Bachelors	25	52
Masters	1	2
Doctoral	1	2
Total	48	100
Nursing Certification		
Yes	9	19
No	38	81
Total	47	100
Years in MSICU		
0-2	11	28
3-5	13	33
6-10	2	5
11-15	5	13
Over15	8	21
Total	39	100

Years in TCU

0-2	18	78
3-5	3	13
6-10	0	0
11-15	1	4
Over15	1	4
Total	23	100

Table 2.2

Moral Distress Levels

Dimension	N=	Mean	SD	f	Sig	Severity Scale	Unit level of severity
Physician Practice 12 items Total possible 0-192	MSICU 31 TCU 16 Total 47	34.3548 21.9375 30.1277	20.08075 16.09749 19.56663	4.581	.038*	None-slight 0-47 Mild 48-96 Moderate 97-143 Severe 44-192	MSICU none to slight TCU none to slight
Nursing Practice 10 items Total possible 0-160	MSICU 33 TCU 16 Total 49	36.2121 35.0625 35.8367	19.78598 19.95150 19.63877	.036	.850	None-slight 0-39 Mild 40-79 Moderate 80-119 Severe 120-160	MSICU none to slight TCU none to slight
Institutional Factors 4 items Total possible 0-64	MSICU 33 TCU 16 Total 49	2.5758 3.6875 2.9388	3.82451 4.60027 4.07946	.036	.377	None-slight 0-16 Mild 17-32 Moderate 33-48 Severe 49-64	MSICU none to slight TCU none to slight
Futile Care 7 items Total possible 0-112	MSICU 29 TCU 15 Total 44	39.5862 48.5333 42.6364	20.80267 22.75919 21.65275	1.716	.197	None-slight 0-39 Mild 40-79 Moderate 80-99 Severe 100-112	MSICU none to slight *borderline to mild TCU mild
Deception 3 items Total possible 48	MSICU 32 TCU 16 Total 48	9.5313 7.5625 8.8750	5.84192 7.08020 6.27601	1.051	.311	None-slight 0-12 Mild 13-24 Moderate 25-32 Severe 33-48	MSICU none to slight TCU none to slight

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Euthanasia 2 items Total possible 32	MSICU 33 TCU 17 Total 50	1.6364 2.2941 1.8600	2.64360 4.10434 3.18805	.472	.495	None-slight Mild Moderate Severe	0-8 9-16 17-24 25-32	MSICU none to slight TCU none to slight

Figure 2.1

Frequency of Leaving a Position

Have You Ever Left or Considered Quitting a Position?

n = 61
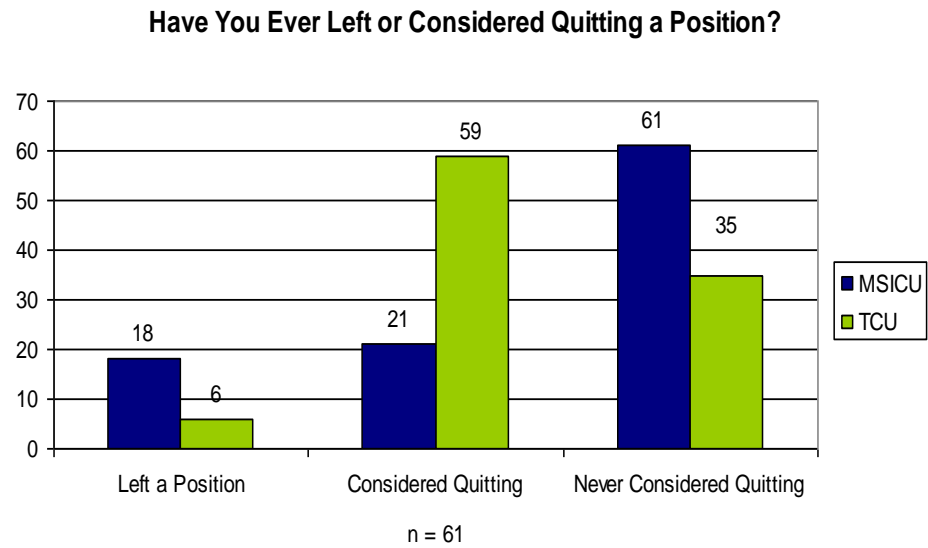
Reported as percentage (%)

Figure 2.2

Impact on Coping Strategies

## Impact on Coping Strategies

Measured in Percent
n= 61
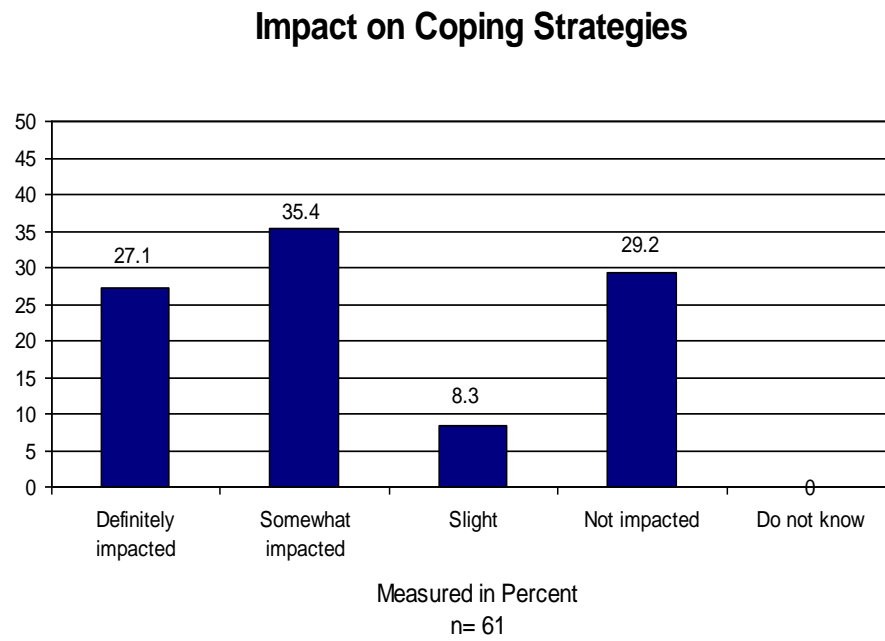
Figure 2.3

Impact on Personal Life

Impact on Personal Life

Measured in Percent
n = 61
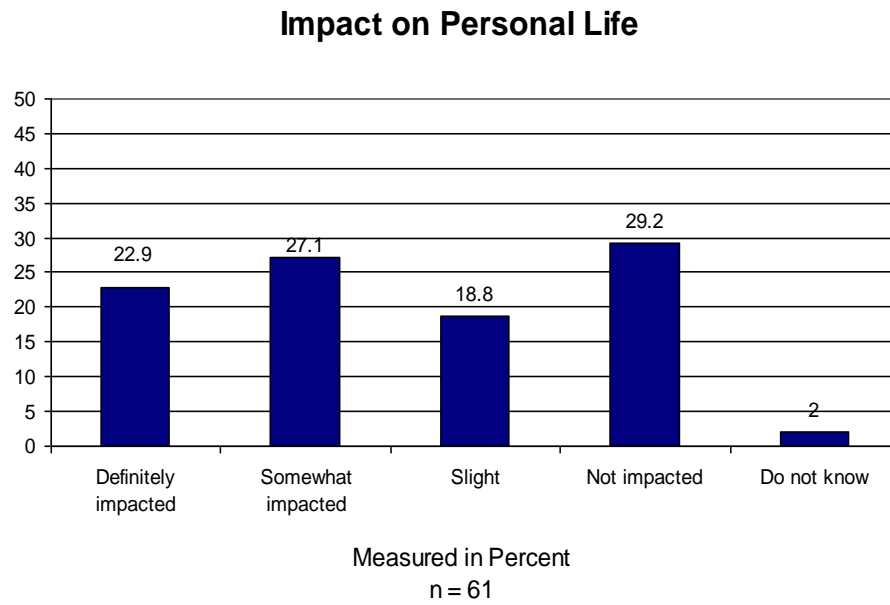
Figure 2.4

Impact on Work Performance

Impact on Work Performance

Measured in Percent
n = 61
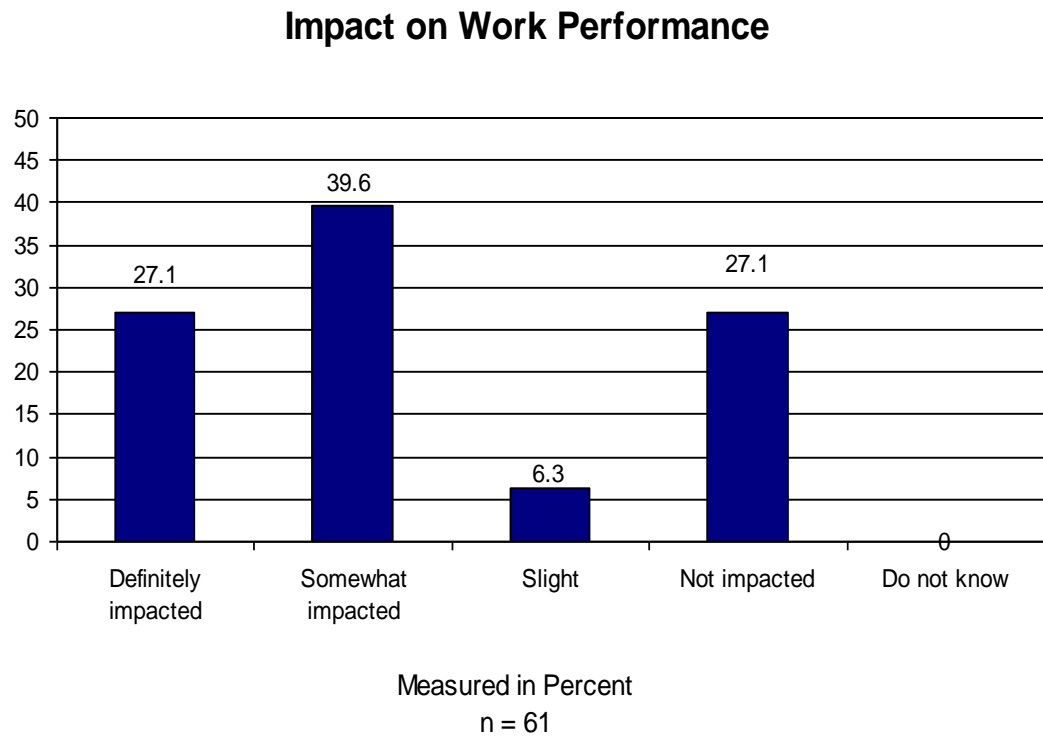
ANALYSIS AND EVALUATION OF THE MORAL DISTRESS THEORY

This is a sole author manuscript that is in preparation for publication submission.

Abstract

Moral distress is a pervasive problem in nursing resulting in harm to patient care, providers, and organizations. Over a decade ago the Moral Distress Theory was proposed and has been utilized in multiple research studies. This middle range theory explains and predicts the distress that occurs in nurses because of moral conflict. This theory provided researchers with a foundational basis to study this phenomenon. Since inception, moral distress has been extensively examined, which has further elaborated its understanding. Application and analysis of this theory reveals gaps in its existing theory model. Current understanding of the phenomenon indicates that a new theory may be warranted to better predict, treat and manage moral distress. This paper provides an analysis and evaluation of the Moral Distress Theory according to procedures by Walker and Avant (2011).

Key Words: Moral Distress; Theory Analysis; Ethics; Theory; Morals; Nurses

Background

Moral distress is an emergent phenomenon in health care that is affecting professionals across various healthcare settings. An increasing empirical and theoretical understanding of moral distress is growing in nursing and related fields (Burston & Tuckett, 2013; Varcoe, Pauly, Webster, & Storch, 2012). Igniting this area of research was the development of a moral distress theory by Corley (2002). The moral distress theory (MDT) has been utilized in numerous studies including those with findings that strongly support moral distress' existence and its negative consequences for the patient, the nurse and the health care organization (Burston & Tuckett, 2013; Cavaliere, Daly, Dowling, & Montgomery, 2010; Corley, Minick, Elswick, & Jacobs, 2005). The MDT is used to clarify what happens when a nurse is unable or does not act according to their moral values and convictions (Corley, 2002). According to Varcoe et al. (2012), research about moral distress has been littered with a lack of theoretical clarity that has hampered its application to policy, education and practice. As research in this area grows, the theoretical model and its constructs are increasingly important to guide this area of research.

A theory provides us with a way to utilize a set of concepts, uniquely combined to identify, express or predict a phenomenon that relates to a particular practice (Fawcett, 2005; Parse, 2005; Walker & Avant, 2011). A theory analysis provides a systematic, objective method for analyzing a theory that may lead to new insight or gaps not previously recognized (Walker & Avant, 2011). The

methods used during a theory analysis should permit an examination of the theory without subjective values or bias. Conversely, a theory evaluation judges the theory's contribution to scientific knowledge and worthiness to use it as a basis for decision-making or actions that can guide policy, education, and practice (Fawcett, 2005; Walker & Avant, 2011). The purpose of this article is to describe the critical analysis of the MDT, including its concepts and constructs, and offer a theory an evaluation.

Method

The steps of this theory analysis were completed according to Walker and Avant (2011) and included the following: (a) examining the origins of the theory and purpose, (b) its meaning, (c) logical adequacy of the theory, (d) usefulness, (e) generalizability, (f) parsimony, and (g) testability.

Literature review

In order to analyze the MDT theory for potential gaps, a thorough evaluation of literature utilizing or discussing the MDT was completed. Formal methods to review articles were conducted to assure a thorough evaluation of literature pertaining to the topic of moral distress. Procedures for analysis included reviewing for (a) relevance, (b) theoretical framework utilized, (c) identifying major concepts and definitions of concepts, (d) instruments used in research, and (e) findings and limitations of the research. Inclusion criteria included articles in the English language, published in peer-reviewed journals, either qualitative or quantitative research study conducted with the MDT utilized or a concept analysis or systematic review of MDT.

The following search criterion was initiated for the topic of moral distress. The search was limited to English-language reports from 1980-June 2015. Substantial literature on the topic of moral distress prior to 1980 is not available. The search took place in Summon® which is a broad search meta-database including 796 individual databases with books, newspaper, images, media, and journals. The Summon® search utilizing the term 'moral distress' revealed 111,427 citations. The citations were limited to articles from scholarly peer-reviewed publications, resulting in 12,374 citations. Further limits were then placed to journal articles only (12,055), moral distress and nurs* (880) and limit to nursing in the subject terms (296). This final list was sorted by relevance to those describing moral distress in nursing which produced 49 sources of literature with abstracts that were reviewed. After reviewing each article, 11 were not included in the analysis due to no contribution to the theory. An additional search engine was utilized from the Joanna Briggs Institute® which revealed 12 citations for the heading 'moral distress'. This search was narrowed to three articles that were included in the final set that pertained to moral distress and healthcare. Finally, email contact with Dr. Mary Corley who developed the MDT produced six more citations (M. Corley, 2012). The total number of articles utilized for the theory analysis was 47.

Results

Origins of the Theory

Step one of a theory analysis according to Walker and Avant (2011) identifies the origins of a theory, which refers to its initial development. This first

step includes what prompted the development of the theory, whether it is inductive or deductive and if evidence exists to support or refute the theory.

Moral distress has been examined in nursing practice since the 1980's. Initially in nursing ethics textbooks, moral distress was defined as knowing the right thing to do but not acting on this knowledge because of institutional constraints (Jameton, 1984; Peter & Liaschenko, 2013). This early definition of moral distress was limited to occupational distress, such as providing care when the outcome will likely result in death or suffering, working with colleagues that are perceived as incompetent, or the lack of disclosure of critical information to patients and families (Corley, 2002; Elpern et al., 2005; Gutierrez, 2005; Pauly, Varcoe, Storch, & Newton, 2009). Wilkinson (1987) describes moral distress as a psychological disequilibrium that is produced by a person making a moral decision and then not acting on this decision. Later, Corley, Elswick, Gorman, and Clor (2001) defined moral distress as, ''the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of obstacles such as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations'' (pp. 250-251).

Researchers have expounded on original definitions of moral distress to include the long range impact that moral distress on the nurse. Lingering effects after the original impact is called reactive moral distress. Initial definitions of moral distress was expanded to include both initial and reactive moral distress. Jameton (1993) identified initial moral distress as "feelings of frustration, anger,

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and anxiety experienced by people when faced with institutional obstacles and conflict with others about values" (p. 421). Initial moral distress reflecting the internal response of an individual at the time the experience occurs. Alternatively, reactive moral distress occurs when people do not act upon this initial distress and their subsequent actions differ because of the previous encounter that is morally distressing.

Moral Distress Scale. Corley et al. (2001) published a tool to measure moral distress that helped to further build the foundation for the theory development. The Moral Distress Scale (MDS) was based on Jameton's concept of moral distress (1984, 1993), House and Rizzo (1972) role conflict theory, and Rokeach's (1973) theory on values and value systems (Corley et al., 2001). This scale helped to quantify moral distress, to conjugate the various moral distress concepts and provided an impetus for future testing. The original MDS utilizes a 38-item questionnaire that asks the participant to rate the frequency and intensity of distressing situations that can arise in the clinical arena.

Moral Distress Theory. As a result of instrument development and testing, descriptive findings, and limited intervention studies, the Moral Distress Theory (MDT) was proposed. The MDT was designed to clarify what happens when a nurse feels powerless to act as a moral agent for the patient resulting in moral distress (Corley, 2002). Since the theory evolved from other theories, it is considered to be deductively evolved. In the MDT model, the opposite of moral distress is moral comfort which is considered the optimal outcome of a moral encounter. The context of the theory lies within the existence of nurses' internal

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and external perception, mental processing and subsequent actions (Corley, 2002).
The internal facet includes the nurses' psychological responses such as perceived
powerlessness or self-doubt and the external component refers to the nurses' work
environment such as differing caregiver perspectives or inadequate
communication. This theory regards the institutional barriers as a major factor in
moral distress.

Evidence exists to support the MDT. Nurse's encounter moral and ethical
situations in their work environment that influence how they act and decisions
they make which influence patient health outcomes (Burston & Tuckett, 2013).
Dilemmas such as providing futile patient care, poor interdisciplinary
communication, staffing issues and perceived physician incompetence are
examples of situations that can lead to nurses' distress (McClendon & Buckner,
2007; Meltzer & Huckabay, 2004; Mobley et al., 2007; Rice, Rady, Hamrick,
Verheijde, & Pendergast, 2008; Whitehead, Herbertson, Hamric, Epstein, &
Fisher, 2015; Wilson et al., 2013). If the severities of a single encounter or
multiple distressing situations are presented frequently, the result could be a
painful disequilibrium and psychological distress (Elpern et al., 2005; Wilkinson,
1987). This distress, defined as the distance from moral comfort in nursing
practice, has been named moral distress and is depicted in the MDT model
(Corley, 2002). Moral distress can result in emotional or psychological discord
leaving nurses feeling powerless, resulting in job dissatisfaction, resignation,
burnout, and/or distancing oneself from patients and families (McClendon &
Buckner, 2007; Meltzer & Huckabay, 2004; Rice et al., 2008).

Meaning of the Theory

Examining the meaning of a theory includes identifying the concepts, definitions, statements and relationships (Walker & Avant, 2011).

Concepts and definitions of MDT. There are eight integrated, dynamic, and nonlinear concepts within the MDT. These moral concepts include: commitment, sensitivity, autonomy, sense-making, judgment, conflict, competency, and certainty. These concepts presuppose that nursing is a moral profession and nurses are moral agents (Corley, 2002). In the analysis, the concepts are presented individually but often interplay with other concepts presented within the theory. For example, a nurse may be able to identify that a moral conflict exists (sensitivity) but lack the desire to act (commitment) because of fear of the consequences.

The concept of commitment was defined as the willingness to take action for a patient based upon the nurses' moral conviction (Corley, 2002). Commitment can be evident before the development of the concept of moral certainty. When nurses feel certain to act on behalf of their moral beliefs, they will act at all costs. Prior to reaching this point they may begin to encounter feelings of wanting to act or even taking subtle actions to act morally on behalf of a patient. In addition, nurses that are morally committed to their patients are more likely to have a high degree of moral competency which will enable a nurse to decipher a moral situation and make the best choices to act that will result in lower levels of moral distress (Corley, 2002).

Within the MDT, moral sensitivity refers to the ability to recognize and

weigh pros and cons of a moral issue on behalf of patients. Nurses are less likely to experience moral distress when they are less sensitive to moral issues (Corley, 2002). Nurses with high moral sensitivity are more likely to be highly committed to their patients and develop high levels of moral competency which results in low levels of moral distress. Even when nurses have high levels of moral sensitivity, they may still experience moral distress when they are either not morally competent or unaware of the moral implications in the situation, or do not utilize strategies to solve ethical problems. Nurses that have high levels of moral sensitivity, commitment, competence, and autonomy are less likely to experience moral distress because they are more likely to experience moral outrage, moral courage, and moral heroism (Corley, 2002).

Autonomy is the ability of nurses to make choices on behalf of the patient for a moral action. Nurses with high levels of moral autonomy may also feel a sense of responsibility to take morally correct action for a patient. This autonomy may be in direct opposition to a patient's moral autonomy but allows the nurse to believe that they are making right choices for a patient. Nurses who have moral autonomy without moral commitment and moral competence are more likely to experience moral distress (Corley, 2002). Autonomous nurses feel empowered to act for what is right despite potential resulting problem or consequences.

The concept of moral sense-making within the model refers to the ability of the nurse to give meaning during moral encounters. This meaning is personal and may not be the same for other health care practitioners or to the patient and family involved in the moral encounter. Nurses experience less moral distress

when they have a high level of commitment, competence and are able to make

sense out of the moral situation (Corley, 2002). In order for the nurse to make

sense out of the moral situation, they must be able to recognize a moral event has

occurred and attempt to mentally process the information.

Moral judgment involves the nurses' ability to consider both sides of a

moral situation and determine the best course of action. The nurse may consider

numerous ethical considerations for moral decision-making. Nurses who have a

high level of commitment, competency, and sense-making are likely to implement

sound moral judgment thereby experience less moral distress (Corley, 2002).

Without the ability to view situations from another perspective, nurses may

experience a high level of distress when occurrences do not end as the nurse felt

was the best outcome.

Conflict involves the discordance between morally appropriate actions and

is a key concept in the MDT. The essential features of moral conflict are choice,

advocacy, autonomy, pain, suffering, values, and relationship (Corley, 2002).

When nurses feel that they are the patient advocates and have the autonomy to

take action but their choices are limited or their values are being violated, they are

more likely to experience moral conflict. The concept of choice was recognized

as the key feature to mediate the strife between moral conflict and contentment

(Corley, 2002).

Moral competency was defined by Corley (2002) as the nurses' ability to

make moral sense of a situation and act with the best moral behaviors. Morally

competent nurses' will feel that they are using the best moral judgment and from

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their perception, are making the best choice in a situation (Corley, 2002). Moral commitment may be high in a nurse but without moral competency, the nurse is likely to experience moral distress. Nurses may not perceive their own moral intention or actions, which can lead to morally inappropriate actions (Corley, 2002).

The last concept in the MDT is moral certainty. This is when a nurse knows with absolute conviction, what is the best course of action to take for a patient. Because of this certainty, the nurse is willing to take risks both personally and professionally. Nurses who have a high level of commitment, competence and autonomy are more likely to feel morally competent resulting in moral certainty (Corley, 2002).

Statements and relationships. Knowledge and utilization of the concepts within the MDT will result in the nurses' experience of moral distress or moral comfort when a moral situation arises. Moral comfort is precipitated by the moral intent to act. When a nurse has the intention to act in a moral situation, they must demonstrate moral courage to set forth actions in place to resolve the situation. Moral courage is the willingness to act on behalf of patients. Once the intent to act transpires to action, moral heroism has been set into motion (Corley, 2002). Nurses who are morally sensitive and committed, but lack moral courage or moral autonomy, will suffer with moral distress due to the overwhelming burden to see moral justice prevail.

Moral agency is a foundational statement in the theory and defined by Lutzen and Kvist (2012) as the moral strength to act on one's moral conviction.

Shafer-Landau (2012) describe moral agency as the ability to control our moral behavior by moral reasoning which gives us a moral duty and we are subject to moral criticism. This moral criticism can be both internal and external to the person. Perceiving or feeling something has moral implications and is not enough to elicit moral distress, the person must sense a responsibility to respond. Moral agency can be regarded as consisting of moral knowledge, moral judgment and moral motivation, in which moral distress plays a role (Lutzen & Kvist, 2012).

Logical Adequacy

Logical adequacy refers to the sensibility and flow of the concept and statements. An analysis of logical adequacy includes a description of the model and determining if it makes sense to move from the concept and statements to predictions in the model. In addition, this part of the analysis evaluates if there is research to support its flow and predictions and whether false assumptions exist (Walker & Avant, 2011).

Description. The model for the theory of moral distress begins with the fundamental principles of nursing being a moral profession and nurses as being moral agents. Once presented with a moral encounter, the use of the concepts described previously (i.e. commitment, sensitivity, etc.) determines whether the situation progresses to either the moral intent to act or moral distress. The moral intent to act and moral courage leads to moral comfort. The MDT assumes that if the intent to act is not carried out than the result is moral distress and negative consequences.

Within the MDT model, if the nurse starts with the moral intent to act,

they must have moral courage to proceed, then onto moral comportment and whistleblowing or to moral heroism, which results in moral comfort. Alternatively, if a moral situation arises and a moral intent to act is not initiated, moral distress/moral suffering/moral residue occurs that then subsequently impacts the nurse, patient, and organization. The resulting implications on the patient in the model are a lack of advocacy and avoiding the patient which then results in increased patient discomfort and suffering. The impact on the nurse leads to suffering which results in resignation, burnout and leaving nursing. Moral distress/suffering/residue impacting the organization in the theory model leads to high nurse turnover, decreased quality of care and low patient satisfaction; all resulting in an impact on reputation and accreditation.

Sensibility. The MDT model starts with fundamental assumptions of nursing and nurses within a box named moral concepts. From there, a linear depiction leads the reader down two tracks, either moral comfort or moral distress. All subsequent connections move onto the next effect. From the foundation of the model, the theory may have been more clearly represented by as dependent on nurses' values as a predictor of moral distress rather than assuming the nurse had values and these values were congruent with the patient, colleague, or organizational values. Recognizing these internal values of the nurse could help to predict whether the moral concepts of the model are utilized. Internal values that if violated, leading to constraints, could encompass the intrinsic component of nurses' actions and be the foundational basis for the MDT. Rather than building the theory on general premise of nurses are moral agents and

nursing is a moral profession, the assumption may be better suited by stating nurses have moral values. The foundation of the MDT is based upon the broad assumption of the profession and nurses in general, distancing the ownership of moral distress from the individual nurse. To base the theory upon the statement that nurses have values relates to the individual nurse that experiences either moral distress or moral comfort. When the nurses' values are threatened, the nurse may experience moral distress (McCarthy & Deady, 2008). A personalized premise to base the MDT on may help to bolster the sensibility of the model by recognizing the effects on the individual nurse.

The fundamental professional values of a nurse are described in the American Nurses Association *Code of Ethics* (2015). These statements serve to guide a nurse in their ethical decision-making, provide a standard for ethical obligations of the nursing profession, and express, to the community, the standards of nursing (American Nurses Association, 2001). Moral values refer to the personal values that are, in most instances, a reflection of the ethical guidelines. When there is differences between the professional ethical guidelines and personal moral values, moral distress can exist which is not clearly addressed in the MDT.

Flow/Prediction/False Assumptions. The MDT model depicts the opposite of moral comfort is moral distress.   Lutzen and Kvist (2012) state that moral distress is closely linked to the psychological component of a person and may actually serve a positive catalyst for acting on another's behalf for moral advocacy. This psychological component focuses on external constraints rather

than focusing on the relational components that are intermingled within the whole process of moral distress (Lutzen & Kvist, 2012). The theory may be better represented to circle back around to represent the effect of moral distress leading to a subsequent moral intention to act or moral courage. The notion that moral distress may lead to a positive reaction and help the nurse recognize that action is needed on behalf of the patient, is not represented within the current MDT model.

The MDT does not account for the frequency and intensity of moral distress encounters. These dilemmas carry with them a burden on a nurse and contribute to the development of barriers to delivering the best patient care in clinical situations (American Association of Critical Care Nurses, 2008). The residual effects of moral distress was earlier named reactive moral distress (Jameton, 1993) and now more recently named moral suffering or moral residue (Webster & Bayless, 2000). Epstein and Hamric (2009) proposed a model that accounts for the experiences of moral distress leaving a lingering effect on the nurse that if left unresolved can continue to build with each subsequent moral distressing encounter. The result can lead to ongoing moral suffering that worsens with each morally distressing encounter. Corley (2002) included moral distress, moral suffering, and moral residue as the opposite of moral comfort in the MDT proposal but did not account for this residual building after multiple or an intense moral distress encounter.

Contrary to the models implications, there may be circumstances when a nurse acts with good moral intention but the result may be a negative outcome that would still result in moral distress. Despite moral intention to act, moral

courage, and the resulting moral comfort that the model would lead you to think would be the result of this action, moral distress may still result. The MDT model tends to imply that once the course of action has been set into place for a moral intent to act that the outcome is moral comfort.

The MDT indicates that the nurse knowingly takes action toward intention to act or the lack of intention which results in moral distress. Moral distress may appear without the nurse recognizing the lack of intention. Hanna (2004) notes nurses are able to consistently describe elements of moral distress even though they may be unable to name them as morally distressing events. Several studies have reported nurses rating themselves as having absent to low levels of moral distress, but then described situations that were morally distressing (Hanna, 2004; Ruggiero, 2005; Wilson et al., 2013). The MDT model does not include the morally distressing events that occur without the nurses' recognition of a need to act or the nurses' inability to name the event as morally distressing.

Future moral beliefs may be formed by previous moral encounters. A nurse may have had a previous morally distressing situation in which they failed to act which may subsequently make them hypersensitive to the next time a similar situation arises. This resulting response would be influenced by the previous encounter. The MDT does not account for these actions or lack of actions to come back to reshape our moral concepts. Kelly (1998) reported that self-criticism and self-blame contributed to a nurses' judgment of standards to reestablish a new professional self-concept. When the nurse reforms and reshapes their moral concepts, the MDT does not depict this cyclical relationship that may

help to reestablish or redefine the moral concepts.

The results of a meta-aggregate systematic review by Huffman and Rittenmeyer (2012) conclude that health care systems with fewer financial resources, weak policies, and poor staffing contribute to the development of moral distress in nurses. In the MDT model, there is a one way arrow denoting the relationship between moral distress leading to the effect on the organization. This may be better depicted with a two-way arrow to represent the impact of the organizational constraints impacting moral distress. Nurses with less organizational support and resources may perpetrate the likelihood or severity of moral distress to occur. Health care organizations overly constrained by socio-political contexts such as driven by finances and other non-health-related values may seriously fail to encompass and encourage a morally sound health care system (Musto, Rodney, & Vanderheide, 2015). Negative ethical climates clearly contribute to the frequency and intensity of moral distress and therefore should be reflected in the theory model.

Usefulness

The usefulness of a theory focuses on the practicality and helpfulness of a theory to help provide understanding or enable predictability (Walker & Avant, 2011).

In the decade following the development of MDT by Corley (2002) major research was done on the topic of moral distress. Despite work in this area, a lack of consensus on the definition of moral distress still exists (Hamric, Borchers, & Epstein, 2012). Jameton's (1984, 1993) definition of moral distress was the

building block for the MDT. This definition mainly included the basis for moral

distress in the occupational (Hanna, 2004) and reactive (Lutzen & Kvist, 2012)

aspects. These theoretical underpinnings have been a main limitation to

explaining moral distress because they do not account for the relational aspects of

moral distress (Lutzen & Kvist, 2012). Instead of nurses identifying moral

distress by the lack of the moral intent to act within their professional role as the

theory suggests, they identify it by biophysical responses that are not included in

the MDT (Huffman & Rittenmeyer, 2012).

Researchers more recently have rebuked Jameton's (1984, 1993)

definition of moral distress for several reasons. Hanna (2004) identified that there

was a mismatch between Jameton's definition, report of research findings, and

additional emergence of distinct themes in the literature about moral distress.

Jameton (1984, 1993) and Corley (2002) focused on the external social and

institutional constraints, while more recently researchers have concluded that that

the definition should also include internal and external constraints felt by the

nurse (McCarthy & Deady, 2008). These dimensions identified in the moral

distress definition are much broader than the psychological reactions to external

constraints but rather provide a psychological, physiological, and

theological/philosophical overlapping perspective (Lutzen & Kvist, 2012).

Nathaniel (2006) defined "moral distress is pain affecting the mind, the body, or

relationships that results from a patient care situation in which the nurse is aware

of a moral problem, acknowledges moral responsibility, and makes a moral

judgment about the correct action, yet, as a result of a real or perceived

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constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong" (Nathaniel, 2006, p. 421). Most recently, Varcoe et al. (2012) defined moral distress as the experience of being compromised as a moral agent to act in accordance with accepted professional values and standards.

Generalizability

Examining the boundaries and evaluating the use of the theory in explaining the phenomenon demonstrates the criterion for generalizability (Peter & Liaschenko, 2013).

The boundaries of the MDT lie within the limited diversity of the research completed utilizing the theory. Early on, studies mainly focused on moral distress in female nurses in critical care and acute care settings within the North American context (Pauly et al., 2012). This suggests possible biases of the research conducted early in the development of the theory. Thus far, the research to generalize the MDT to the broad nursing profession and to other health care professions remains somewhat limited by the lack of diversity involved in developing the concepts of the theoretical model.

Initially, several studies did not start out to identify moral distress, but overwhelming descriptions of the phenomenon lead to the conclusion of moral distress (Hamric et al., 2012). Hanna (2004) wrote that 34 out of 35 studies on moral distress explored the occupational side of moral distress and did not involve the internal component of the nurse. Since the model's proposal, several new concepts have emerged. Moral distress, moral stress, stress of conscience, moral sensitivity, ethical climate and moral agency have surfaced as construct

relationships that interplay to impact moral distress (Lutzen & Kvist, 2012).

McCarthy and Deady (2008) proposed a complete revision of the concepts used for moral distress. These authors ask for an intensive evaluation of the existing concepts utilized and examination of the new concepts that more recent research and analysis has provided (McCarthy & Deady, 2008).

Parsimony

Parsimony is its broadness to application. A broad but applicable theory results in a highly parsimonious theory (Walker & Avant, 2011). Parsimony refers to the simplicity of the theory to explain the phenomenon. A parsimonious theory explains a complex phenomenon without sacrificing the theory's content, organization or thoroughness (Walker & Avant, 2011).

At the time of creation, the MDT was a parsimonious theory model. This very complex phenomenon was reduced to a fairly simplistic representation of moral distress. Since the development, researchers have utilized its premise to test the concepts and implications of moral distress. This research has revealed a much broader phenomenon with concepts and relationships that may not have been originally considered. The state of the science has exposed the simplicity of the model may also be its limitation.

Since the development of the MDT, the theory has provided a base in which to propel an exorbitant amount of new research and analysis. Initially, the MDT was useful to start the conversation about this pervasive problem in health care. Further research using the model and its concepts and relationships has enabled scientist to view moral distress somewhat differently than the original

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model depicts. "Research on moral distress is plagued by a lack of conceptual and theoretical clarity that in turn, has hampered action on moral distress in education, policy, and practice"(Pauly et al., 2012, p. 2). Instead of clarifying the concepts in the MDT, testing has blurred the phenomenon further.

Testability of the Theory

According to Walker & Avant, the testability of a theory implies that hypotheses can be generated from the theory, research performed, and supported by evidence (Walker & Avant, 2011).

For several decades the MDT has been tested and analyzed. The literature reveals that moral distress is a major problem in nursing and frequently ignored (American Association of Critical Care Nurses, 2008). Development of the MDT precipitated new research regarding the topic. Research utilizing the theoretical foundation has also branched out beyond nursing to other disciplines such as pharmacist and physicians (Hamric & Blackhall, 2007; Schwenzer & Wang, 2006). Studies have also been conducted in various countries such as Israel, Canada and Japan focusing on various nursing specialties such as critical care, medical-surgical, psychiatric and nursing home environments (Corley, 1995; Ganz et al., 2013; Ohnishi et al., 2010; Pauly et al., 2009).

Qualitative Research

Qualitative research in the area of moral distress has primarily consisted of open-ended questionnaires and interviewing techniques (Hamric, 2012). Qualitative studies have revealed that participants experienced moral

distress beyond the external constraints identified in Jameton's definition of moral

distress (Jameton, 1984, 1993). Root cause examples of moral distress identified

by Hamric (Hamric, 2012) were: (a) factors internal to the caregiver, (b) factors

external in the situation, and (c) clinical situations. These causes engender an

interconnection between individual, unit/team, and system factors. Huffman and

Rittenmeyer (2012) performed a systematic review of qualitative studies on the

topic of moral distress and found that nurses experience moral distress when they

fail to act on behalf of a patient's best interest, especially in situations of unequal

organizational structures that can result in physical symptoms such as rapid heart

rate, gastrointestinal symptoms and fatigue.

Quantitative Research

Quantitative studies have primary utilized the Moral Distress Scale. As

noted previously, this scale was built upon the same premises of the MDT for the

use in critical care environments. The MDS has been modified and adapted for

various environments such as in the pediatric, medical-surgical and ICU

environments. It has been used to study different nationalities including Canadian

and Israeli nurse populations (Aft, 2011; Elpern et al., 2005; Ganz et al., 2013;

Hamric & Blackhall, 2007; Pauly et al., 2009). A revised MDS has been

developed that captures both moral distress and moral residue (Hamric &

Blackhall, 2007). Several other variations of measurements have been utilized

based upon a variation of Jameton's core definition or other related concepts such

as ethical competence and moral sensitivity (Lützén et al., 2006; Sporrong,

Arnetz, Hansson, Westerholm, & Höglund, 2007; Wiggleton et al., 2010).

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Issues with the original MDS have been noted as problematic regarding its length and multiple variables analyzed (Aft, 2011; Volpe, 2011; Wocial & Weaver, 2013; Zuzelo, 2007). In one of its shortened versions, this scale was used to focus only on the experience in nurses and physicians in end-of-life situations. While useful for end-of-life experiences, the entirety of constructs examined in the experience of moral distress examined in this shortened MDS are lacking (Hamric & Blackhall, 2007). Mirroring the fundamentals of the MDS, Hamric et al. (2012) introduced an updated tool named the Moral Distress Scale-Revised (MDS-R) that is shorter in length and has six parallel versions applicable to health care professions outside of nursing. In a newly published study utilizing this revised MDS, Whitehead et al. (2015) found the tool highly reliable to measure moral distress in nurses, physicians, and other health care providers.

Hamric (2012) recommends future research on moral distress should include primarily a mixed methodology approach taking place at multi-site settings using previously validated instruments. Utilization of the MDT for future studies may need to include revisions with the newly developed concepts and relationships. Oh and Gastmans (2015) completed a quantitative literature review of moral distress research and concluded that further research is needed to clarify the concept and provide for a more coherent term to conduct intervention programs addressed at organizational factors. Additionally, Hanna (2004) recommends that the theory be applied to examining moral distress in our patients. If it is evident that nurses and other disciplines in the health care arena experience moral distress in these setting, it is possible that patients' also

experience moral distress. The current MDT does apply only to nurses and not patients.

Conclusion

This analysis and evaluation provided a detailed examination of the theory and its current state. Concepts, propositions and themes have emerged in the phenomenon to beckon for a model that more reflects the current state of the science. If the concepts and propositions are tested and the theory no longer fits then a new theory is selected (Fawcett & Desanto-Madeya, 2013). Researchers have come a long way to understanding and refining the constructs and statements of the MDT since its inception. The multitude of new research has given us the opportunity to understand the phenomenon of moral distress more thoroughly. This enrichment has left some researchers asking if it is time for a new moral distress theory.

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CHAPTER FOUR

VALUES AND BARRIERS OF MORAL DISTRESS

AMONG INTENSIVE CARE NURSES

This is a co-authored manuscript to be submitted for publication.

Abstract

Aims. To understand the barriers and values described by critical care nurses who have experienced moral distress. **Background.** Moral distress is a phenomenon frequently identified by critical care nurses who experience moral conflict while caring for others in a healthcare environment. When conflict occurs, moral distress may influence actions and behaviors of that individual and result in a negative outcome for the person, others and the healthcare system overall. Identification of specific barriers and values within the context of moral distress may lead to crucial interventions that could lessen the effects of moral distress on nurses. **Design.** A nonexperimental descriptive study utilizing qualitative interviews with critical care nurses who self-report that they have experienced moral distress. **Methods.** Primary interviews were conducted with seven critical care nurses utilizing a semi-structured approach. Recruitment occurred through a local chapter of a professional critical care nurse organization. **Results.** A content analysis approach was utilized to identify five barriers and associated values expressed by critical care nurses during moral distress experiences. Barriers in moral distress experiences involved the nurse, patients, colleagues and organization. Values within these barriers were identified and

defined according to professional standards used in nursing. **Conclusion.** A set of

barriers and values identified by critical care nurses who experienced moral

distress emerged from their stories.   **Relevance to clinical practice.** Studying

specific values and the barriers experienced by critical care nurses who have

experienced moral distress provides direction for targeting interventions to lessen

the impact of this detrimental phenomenon in healthcare.

Moral distress is present in our current health care system and has implications for the safe delivery of optimal healthcare. This phenomenon is eroding the fundamental principles of caregiving among nurses. "Moral distress is pain affecting the mind, body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong" (Nathaniel, 2006, p. 421). The impact of moral distress is increasingly problematic in healthcare because of the use of advanced technologies to extend life, multidisciplinary team-based care, constraints in health care resources and an increasing demand of high quality, trusted care (Burston & Tuckett, 2013; Oh & Gastmans, 2015). It is estimated that one in three nurses experience moral distress and as a result may leave their unit, their organization or nursing altogether. (Millette, 1994; Redman & Fry, 2000; Wilson et al., 2013). The impact of moral distress is so great that the American Association of Critical Care Nurses (AACN) has issued a call to action for nurses to identify and name the experience of moral distress and for organizations to commit to using professional and institutional resources to alleviate its impact (AACN, 2008).

In the past decade, research has enhanced our understanding of moral distress. Even though there is an increased awareness of its existence, interventions to limit its impact on nursing and the healthcare community at-large are limited. Researchers have indicated the urgency of research that will continue

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to further our understanding of moral distress but also identify interventions to protect the integrity of our healthcare providers (Hamric, 2012). Understanding specific interventions for this phenomenon are challenging because a nurse's values are subjective and specific to the individual. The purpose of this study was to: 1) explicate values identified by critical care nurses that have experienced moral distress, and 2) understand barriers critical care nurses have encountered during moral distress experiences. These findings will be used to begin future work towards identifying interventions to lessen the impact of this phenomenon on professional nurses.

Background

Moral distress impedes nurses from delivering the best possible care to patients. When moral distress is present, barriers exist to providing the best care by not allowing nurses to act upon their personal and professional values (Corley, 2002; Nathaniel, 2006). In the United States, at the point of becoming licensed, nurses commit to a set of professional values guided by the American Nurses Association (ANA). These professional values along with their personal values become actionable statements that a nurse may use to make and evaluate decisions about nursing care (Weis & Schank, 2000).

Personal values can be influenced by standards of a societal group that then determine personal actions and behavior (Bao, Vedina, Moodie, & Dolan, 2013; Rokeach, 1973). Nurses have both personal and professional values that guide decision-making or actions in their scope of work (American Nurses Association [ANA], 2015). The ANA *Code of Ethics for Nurses* (2015) details

fundamental professional nursing values. Statements made in this guidebook direct a nurse in decision-making, provide a standard for ethical obligations of the nursing profession, and express to the community the standards of nursing (ANA, 2015). Practicing nurses make a choice about whether to fully integrate the values of the profession and utilize them as if they are 'prescriptive statements' of ethical expectations and actions (ANA, 2001, p. 5). When personal and professional values do not align or the values of others conflict with those of the nurse and the nurse is not equipped to adequately resolve the situation, moral distress develops.

Methods

A nonexperimental descriptive study using qualitative approaches was conducted. A qualitative research design provides the opportunity to discover the values and barriers expressed by critical care nurses who have experienced moral distress. A content analysis of qualitative data was utilized to arrive at a comprehensive summary of values and barriers identified by critical care nurses who experienced moral distress (Sandelowski, 2000). Utilizing a constructivist approach to performing a descriptive qualitative content analysis methodology allows the researcher to hear about a nurses' experiences while engaging in simultaneous data collection and analysis and to identify emerging categories and themes from the descriptive statements (Polit & Beck, 2012; Charmaz, 2011). Furthermore, this method promotes the collection of a large quantity of detailed data and helps to elicit a broad understanding of patterns, characteristics and meaning of a phenomenon (Merriam & Tisdell, 2016). Qualitative content

analysis methods are highly reflexive allowing for themes and patterns that emerge to be explored for meaning and context.

Sample

The AACN organization is the largest specialty nursing organization in the world and represents over 500,000 critical care and acute care nurses worldwide (AACN(b), 2015). The local organization used in this study had approximately 200 members at the time of recruitment (AACN(b), 2015). Recruitment for this study occurred through a local Ohio AACN chapter and by word-of-mouth. In the region where this study took place, AACN members and nonmembers attend their monthly education offerings with an average attendance of 25-50 nurses. The AACN national and local chapters were agreeable to solicitation of participants both on the internet and at the local AACN chapter meetings (see letters of support, Appendix 5). The target sample size for this study was 12-15 critical care nurses who were members of AACN and self-identified as having experienced moral distress. Nurses from subspecialties of critical care such as cardiac intensive care, stepdown or telemetry unit, or emergency care units were accepted.

The sample size was estimated initially based on recommended descriptive qualitative approaches. The final number of interviewed participants was consistent to other published moral distress studies with a similar methodology (Edison, Lunardi, Lunardi, Tomaschewski-Barlem, & Rosemary, 2013; Hanna, 2005; McClendon & Buckner, 2007). Sample size was adjusted as interviews progressed until a point of data saturation was reached (Charmaz,

2014; Guest, Bunce, & Johnson, 2006). According to Merriam & Tisdale (2016), saturation is reached and sampling is terminated when redundancy is seen and data repetition is reached. Charmaz (2014) stated a very small number of participants can produce an in-depth interview of lasting significance. All methods were approved by the university's Institutional Review Board under project #2002853.

Inclusion/Exclusion Criteria

Interviews were conducted with critical care nurses that met inclusion/exclusion criteria. Inclusion criteria included current registered nurses with greater than one year experience in critical care (e.g. intensive care, surgical intensive care and coronary care intensive care units) who self-reported experience with moral distress. Critical care nurses were targeted for recruitment because these professionals frequently encounter situations that lead to moral distress in the intensive care environment (Cronqvist et al., 2006; McClendon & Buckner, 2007). Through a purposive sampling approach, critical care nurse participants were based on ethnicity, age, specialty experiences and gender to produce a wider view of subject experiences and interpretations. A purposive sampling approach can traditionally target and reach hard to get populations because the researchers' situated knowledge of the population and rapport with the members of the identified network (Barratt, Ferris, & Lenton, 2015). Subjects were excluded if they were not a registered nurse or had less than one year of experience in a critical care area. Subjects received no reimbursement for participation in any component of this research study.

Recruitment

After institutional review board approval was obtained, participants were recruited from a local Ohio AACN chapter through board meetings, advertising on their website, Facebook™ page and through an announcement to chapter members at their monthly educational events. Nurses were provided an inquiry form at the educational event and asked to return the form to the researcher if they were interested in participating. The inquiry form contained information about the study, recruitment and the definition for moral distress utilized in this study. This same definition of moral distress was used throughout the study solicitation, data collection and data analysis phases. This form contained a description of the project, the inclusion criteria with yes/no responses and instructions to be eligible to participate. If the nurse met the inclusion criteria, was open to participating and met the selection criteria for the purposive sampling, an interview was arranged at their earliest convenience.

Data Collection

Once participants were successfully recruited, the researcher traveled to the subjects preferred location to meet in order to accommodate working nurses. The interviews took place at several locations including work, home and public locations like a conference room at a public library per the participants' request. All interviews were conducted by the primary researcher. At the interview, consent was obtained and a copy was given to the participant with contact information of the researcher if they wanted to share more information after the interview concluded. The interviews were audio recorded. At the conclusion of

the interview, the subject was asked to complete a demographic form. Demographic questions were developed from preliminary work conducted in a previous moral distress study (Wilson et al., 2013).

Interview

After consent was obtained, the interview started with a rapport building exercise that included an explanation of the study and the PI's background and interest in the topic of moral distress. The interview questions were semi-structured to include a few initial open-ended questions to all participants, such as "tell me about where you currently work" and "is this the same place that you experienced moral distress" (Richards & Morse, 2013). Initial questions were designed to allow the participant to gain comfort with the interviewer and with the topic of discussion so that depth of the topic could be attained. Then, after the initial questions, the PI asked intermediate level questions about the nurses' experiences with moral distress situations. The qualitative approach used in this research started by asking subjects about their experience with moral distress and encouraging each subject to construct a story or give a picture of the situation (Charmaz, 2014). Using this approach, nurses were asked to elaborate about details of their experience with moral distress. Various intermediate level questions were selected based upon the initial responses of the participants and discussed until the story was exhausted or the participant ended the discussion. New questions were developed as data were analyzed between subjects to further elaborate on hunches and categories that developed during the content analysis. The interview concluded with closing questions to all participants such as "is

there anything else that you would like to share" or "did you have the opportunity to share all that you would have liked to share during this interview".

Audio recording of the interviews was conducted to ensure accurate records of the session. The audio files and any associated field notes were sent to a medical transcriber upon completion of the interview. Once transcribed into Microsoft Word™ files, the researcher reviewed the records for accuracy and ensured that participant identifiers were removed. Each subject and transcript was assigned a corresponding number for identification purposes only.

Trustworthiness

Validity, reliability and objectivity were maintained throughout the study. Expert review was a strategy undertaken to ensure validity by assembling a team of experienced researchers to discuss the process of the study, congruency of emerging findings and tentative interpretations (Merriam & Tisdell, 2015). The research team consisted of experts in the area of moral distress, ethics, critical care and qualitative methods to guide the generation of the research questions, framework, appropriate methodology and conclusions. The primary researcher, along with an experienced critical care nurse researcher and a researcher experienced in qualitative methodology were consistently reviewing the data and audit trail to ensure credibility of the analysis and conclusions. In addition, internal validity or credibility was checked by respondent validation. This method entails soliciting feedback or validation of emerging findings with subjects (Merriam & Tisdell, 2015). As themes emerged through preliminary data analysis, subject feedback was solicited from subsequent participants by

asking questions such as "If I am hearing you correctly, you are saying…" To

heighten the trustworthiness of the study, an audit trail was recorded so that

events and decisions could be checked and referenced (Richards & Morse, 2013).

Triangulation was performed by the research team by comparing and cross-

checking data collected at various points of data analysis (Merriam & Tisdell,

2015). Since the primary investigator was experienced in the area of moral

distress, a list of biases and assumptions was developed prior to undertaking the

study and referred to throughout the analysis. Objectivity or confirmability is

determined by interviewing experienced critical care nurses from various age

ranges, levels of education and experience levels, so that results could confirmed

regardless of the characteristics of the individual participant.

Data analysis

In qualitative methodology, the analysis evolves as data is collected and

interpreted (Charmaz, 2006). Qualitative methods allow the researcher to go

back and forth between data collection and analysis because each step informs

and advances the other. Researcher field notes taken during and after each

interview helped the investigator to confirm insights, hunches, themes or

additional thoughts about the interview (Richards & Morse, 2013). Field notes

were processed along with the participants' recordings to verify the barriers and

values expressed by participants and assert the validity of findings when

comparing recorded verbal comments.

The de-identified raw transcripts from each interview were placed

in a Microsoft Word™ format for subsequent coding processes and content

analysis. Transcribed data was migrated into a spreadsheet format within Microsoft Excel™. Analysis began after each interview using Charmaz (2006) qualitative approach which consists of an initial coding procedure called first cycle coding. First cycle methods are those processes that happen at the beginning of coding data and are utilized to analyze raw data from transcripts and field notes (Saldana, 2013). This cycle assists to break down the raw data into workable parts by extracting the key meaning and eliminating extraneous words used when participants share their stories.

During the initial coding of first cycle methods, every part of the data, line by line, is analyzed including raw data from the subject and interviewer. As the data is analyzed, the researcher assigns labels or codes directly from the words of the participants and utilizes them as the foundational process for emerging themes (de Chesnay, 2015; Richards & Morse, 2013). This initial coding stage and the memos produced were used to formulate the beginning classification schema for the barriers and values identified by nurses. This schema was then used in the next stage of the analysis, called second cycle coding.

The primary goal of second cycle or focused coding is to concentrate on the themes from the first cycle and to test them against content both within and across interviews to get an overall sense of the conceptual organization of the story (Charmaz, 2014; Saldana, 2013). Specific descriptors were extracted from the list of initial codes during second cycle coding methods and then began to form the category of barriers. As barriers evolved after each completed interview, all interview data was revisited to ensure ideas and hunches were validated. Barriers

were refined based on an iterative process of reviewing second cycle codes and returning to the raw data if necessary. Once barriers were identified, each story was analyzed for the values that nurses expressed when telling about moral distress experiences.

Codes generated from qualitative statements were sorted according to barriers described, reviewed again for consistency and then values were assigned according to the content where barriers were identified. A core list of values was developed by consulting an expert ethicist and conducting a literature review which produced a suggested list of 34 professional or personal values that a nurse may hold. The data collected from participants to support the barriers was labeled for the values contained within the stories. This list was then condensed to a list of 16 values and defined according to the ANA *Code of Ethics* (2015) (Table 1) as the barrier stories were again reviewed and values were assigned from the data. A list of the barriers with corresponding values and supporting statements was then produced (Table 2). This table continued to be edited and evolved as team members iteratively reworked through the coding schema.

In this study, barriers are defined as values that could not be acted upon that resulted in moral distress. A total of 16 values were extracted from the stories. Values were extracted from first and second cycle codes initially and then the raw data was revisited to ensure an accurate identification. Barriers and values came from the nurses' descriptions of their experiences with moral distress.

During the third and last cycle of coding, researchers utilized focused

codes from the second cycle coding to specify relationships between barriers and the corresponding values. An iterative process was used during this cycle to ensure the emerging barriers and values were all accounted for in the data. Once all the barriers were saturated and values identified, conclusions were made. The product is an overall description of the barriers and values described by the seven critical care nurses who had experienced moral distress. The data is presented in a way that depicts the overall description of the barriers and values with associated qualitative statements that support the findings.

Results

A total of 14 subjects agreed to participate in the study; however, only 7 subjects scheduled interviews and completed the interview process. All participants who were interviewed were female and age 20-61 years. Additional AACN chapter meetings were attended and Facebook™ posts sent to attempt to garner male participants, without a response from male critical care nurses. Six participants identified as 'non-Hispanic, white race' and one identified as 'black, afro-Caribbean, or African American'. The religious affiliations were all 'Christian'. Education was identified as 'Bachelors' ($n=4$) and 'Masters' ($n=3$) prepared. Years of experience ranged from 'less than 3 years' to 'greater than 30 years'. Demographic information is displayed in Table 3.

Interviews ranged from 65-130 minutes in length. Participants were interviewed from a tristate area of Indiana (n=1), Ohio (n=4) and Kentucky (n=2). Six nurses were currently employed in healthcare and one retired from nursing in the past year. Of the six employed nurses, one worked in an outpatient clinic, two

worked in research, two worked as bedside nurses and one nurse worked in the education department of a hospital. Five nurses were currently employed at different organizations, and two nurses who were from the same facility but worked in different departments of the same organization. Each nurse spoke about various unique healthcare organizations throughout each of their experiences as professional nurses.

Barriers and Values

The first cycle coding stage yielded 880 lines of initial codes from the seven interviews. These codes provide a label or summary of the description and were derived 'in vivo' from the stories and the raw words used by the participants. Initial data points formed from the first cycle coding were then used in the second cycle coding methods to develop into a list that included 322 focused codes. This list was then examined for barriers and categories using the interviewees supporting statements. Many of the codes were repetitive such as 'care for others' and 'caring for others' so they were counted twice as examples of similar concepts even though it was defined and coded essentially the same. Thirteen barrier categories evolved which was refined to ten because of some overlapping concepts. These ten barriers were extensively refined through iterative review and removing redundancy resulting in five total barriers, described in this manuscript (Table 2).

Falling short of personal expectations

The barrier 'falling short of personal expectations' was defined as a

nurse's reflected feelings associated with being unable to meet what they believed was their professional and/or personal obligation to do their very best.   Nurses often discussed an internal dialogue about "failing" or "falling short" when sharing experiences that caused moral distress as represented by a nurse stating "It's really hard on the nurses and then the nurses don't feel like they're giving good care" and "I felt responsible to the other nurses as their leader and those roles are in conflict if there is not enough of you to go around for all of them.". Other examples of this barrier can be found in Table 2. Accountability, advocacy, altruism, compassion, integrity, fidelity, respect for persons, responsibility, and self-regarding duty were values present when nurses told stories of moral distress that were categorized under this barrier. Being unable to act on these experiences served as a catalyst for their moral distress experiences. Nurses spoke about situations where they could have done better or someone suffered because they felt responsible for poor results. At times these results were inevitable, such as when someone died because of stage four metastatic cancer, but it was their perception of their shortcomings or "inability to do it all" that produced these moral distress experiences.

Inadequate training, preparation, education or mentoring

The next barrier was named 'inadequate training, preparation, education or mentoring' and included values of accountability, altruism, beneficence, collaboration, competence, courage, fidelity, justice, nonmaleficence and responsibility. Nurses describing this barrier valued competence and expertise and believed they were inadequate when floated to another unit, were unfamiliar

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with the patient's medical diagnosis, lacked skills required to care for a patient, and insufficient skills needed to operate unfamiliar equipment. Nurses in this sample felt a duty to their patients but at critical times were unable to act appropriately because of a lack of training, preparation education, or guidance by another nurse. In addition, six of the seven nurses interviewed shared stories of moral distress when unable to mentor other nurses or when they desired other nurses to mentor them and they were unable to or not available. When discussing the situations that were identified in this barrier category, a nurse expressed that "we need to be better advocates for ourselves" by involving ourselves in the creation of policies and procedures, and continually seeking training and support to develop expertise in unfamiliar areas.   A lack of resources available to help gain knowledge and expertise put nurses into situations that pitted nurse against nurse as they advocated for their own needs and scarce resource allocation. As an example, a nurse stated that only a limited number of nurses were supported to attend conferences or learning opportunities because of the limited resources available. The importance of mentoring was expressed when nurses shared stories of moral distress resulting from not having either good mentors or not being able to adequately mentor other nurses because of limiting situations, such as when there was not adequate staffing.   As an example, a nurse that had graduated from nursing school a year prior talked about being the most senior nurse on the unit for a shift and was expected to mentor a nurse more junior, both nurses had a "full patient load". Six out of the seven nurses spoke about the distress experienced when other nurses are "counting on you" to help, but they

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were constrained from helping.   Two nurses spoke about the importance of leaving a legacy to the less experienced nurses by mentoring and modeling the behaviors of an admirable senior nurse.

Nurses expressed that immediately after finishing nursing school was a crucial period for moral distress. Nurse's described their feelings during this time as "this was not what I was prepared to do" or "nursing school did not prepare me for this" or "some nurses are unable to talk to patients [or families] about that [end-of-life decisions], we aren't prepared for that." Experienced nurses spoke about the stories of moral distress when they first began to practice as a professional nurse. One nurse spoke about her lack of being mentored twenty years ago impacting her practice today. She spoke about being hypersensitive to the newer nurses and trying to ensure that each nurse is properly mentored to the units.

Insufficient organizational support

The next barrier was 'insufficient organizational support'. This category was defined as actions, behaviors or resources within the healthcare organization that negatively influenced nursing or the nurse. The values that were present in these stories were accountability, advocacy, beneficence, compassion, justice, nonmaleficence, respect for persons, responsibility and self-regarding duty. Nurses detailed many stories of understaffing, leadership not communicating a vision, poor management, unreasonable practices resulting from regulatory body requirements, drivers for reimbursement, and policies and procedures resulting in barriers to providing care that caused moral distress.

Staffing was a reoccurring theme. Moral distress was less likely according to the nurse's stories when staffing was sufficient, or even when it was below regular staffing levels but adequate, and there was the availability of a charge nurse or a float nurse to help when patient care needs were overwhelming. Conversely, if the charge nurse had a full patient load, staffing numbers were less than optimal, and something with a patient went wrong requiring greater attention, nurses spoke about the moral distress experienced by not being able to care for their other patients while caring for the patient with the highest needs. A nurse stated "it just depends on who the nursing supervisor was; some nights it was really good and I could depend on them then other nights it was really bad and they were an obstacle". Other examples were stated as "I felt like my manager did not care about me", "why should I help you [organization] when you don't even support me in my job", and "there was new buildings going up all around us but we couldn't even get basic supplies for the patients or adequate staffing to care for patients". Additional excerpts from stories of this barrier are found in Table 2.

Untrusting relationships with nurse colleagues

Another barrier identified was 'untrusting relationships with nurse colleagues'. This was defined as a situation where nurses had or had not formed deep positive relationships while, "working in the trenches with one another". The values present were advocacy, beneficence, collaboration, compassion, integrity, nonmaleficence, respect for persons, responsibility, and self-regarding duty. A term coined by one of the nurses interviewed, exemplifying these connections was

"war buddies". All nurses interviewed spoke about some experiences of moral distress that was influenced by a lack of positive relationships with a nurse colleague. Nurses shared stories of moral distress when did not have these deep and personal relationships with their nurse colleagues. Examples included "I worked with agency nurses quite a bit, but because we worked often, I knew I could trust them" and then "I felt confident as a charge nurse". There were descriptions where a lack of trust led to "judging" patients and other nurse colleagues; eventually leading nurses to emotionally disconnect, because it made them "too vulnerable" to the effects of the situation. Finally, working with patients, families and other staff who had a "sense of entitlement" led to feelings described as being treated as a "beating bag". More excerpts can be found in Table 2.

Inappropriate or controlling actions or behaviors of non-nurse providers

The last barrier was named 'inappropriate or controlling actions or behaviors of non-nurse providers' which was defined as professional relationships that negatively impacted a situation. These experiences included physicians and other ancillary members in the hospital such as chaplains, social workers, respiratory therapists, and nursing assistants. The values depicted in the stories of moral distress in this category included accountability, advocacy, collaboration, compassion, competence, courage, fidelity, integrity, justice, nonmaleficence, respect for persons, responsibility and self-regarding duty. All seven nurses reported moral distress stories that exemplified this barrier category. Examples

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included physicians expecting nurses to practice outside of their scope, like a time that a nurse was threatened with punitive actions if she did not advance a cardiac wire through the patient's sternal cavity. Another nurse shared a story of a urinary catheter being clotted off after urinary surgery and the physician refusing to come back and see the patient, despite the nurses repeated calls. Nurses shared stories of non-nurse providers rounding on the patient when the nurse was not present which made it difficult to be aware of changes and updates to the patient care. This lack of continuity made knowing the plan of care difficult and increased the likelihood of obstacles in caring for the patient.

Nurses shared stories where they stated moral distress intensity or frequency was decreased because of a positive interaction with a non-nurse provider. For example, a nurse spoke about the nursing supervisor prevented adequate care to be delivered to a patient by forcing newly admitted patients to arrive on the floor during a period when chaos had erupted on the unit because of disoriented patient with mental and physical health needs. The nurse stated that there was "so many bad things that could have happened", but "everyone worked together [excluding the nursing supervisor]" to provide the best care for the patient. The nurse described the nursing supervisor as the barrier causing moral distress and the non-nurse providers were advocates that helped her reach moral comfort. Another example, a nurse spoke positively about her relationships with the physicians and that "anytime there is trouble" with a patient, "I am able to pick up the phone and call them". She shared that "we always have each other's back".

Discussion

The aim of this study was to identify the barriers and values of critical care nurses when describing situations where they experienced moral distress. Barriers and the corresponding values present during moral distress situations were explicated from the stories as told by nurses. These study findings revealed barriers experienced by the critical care nurse during morally distressing situations are both internal and external to the nurse. Common sources of moral distress experienced by nurses arise from individual character traits, worldview, experience, and established relationships (Burston & Tuckett, 2013). The barriers identified in this study were consistent with root cause examples of moral distress identified by Hamric (2012) as: (a) factors internal to the caregiver, (b) factors external in the situation, and (c) clinical situations. These causes point to an interconnection between individual, unit/team, and system factors (Hamric, 2012). Huffman & Rittenmeyer (2012) performed a systematic review about the experience of moral distress and the experience of moral distress was extracted as: (1) human reactivity, (2) institutional culpability, (3) patient pain and suffering and (4) unequal power hierarchies. The five barriers in this study identified pertained to the nurse, the organization, the patient and relationships with colleagues.

A list of sixteen values were identified within the barriers of moral distress experiences and defined according to the ANA *Code of Ethics* (2015). Nurses experiencing moral distress encounter conflict between their personal and/or professional values. Value systems are sets of beliefs about truth and

worthiness of thoughts, objects or behaviors and may be described in terms of the person, a professional or societal value system (Guido, 2010). When conflict occurs, individual values or a set of values may influence their actions and behaviors. Conflicting values occur when the value systems are different, which can give rise to differing behaviors (Bao, et al. 2012). Identification of specific nursing values that conflict with personal and/or professional value systems allows for more impactful interventions for nurses experiencing moral distress. Assessment of moral distress and interventions to lessen the impact on a nurse have been particularly challenging due to the subjective and personal nature of the individual's experience of moral distress (Burston & Tuckett, 2013). Research directed at identifying values and barriers experienced by nurses is one way to begin identifying effective interventions for moral distress (Musto et al., 2015).

Building on the principles of Jameton (1993) original definition and grounded in the most current theoretical perspective of context, Varcoe et al. (2012) proposed the latest definition of moral distress being "the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment" (p. 59). This relational experience is highlighted as it relates to the professional and personal values of the nurse and demonstrated in the barriers described by critical care nurses in moral distress experiences. Awareness of specific barriers and the corresponding values may help healthcare providers to understand moral distress more thoroughly and to target specific interventions to lessen its impact on the profession.

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Limitations

Limitations in this study are the small number of critical care nurses who were interviewed and the nurses lacked diversity. In addition, nurses were recalling experiences of clinical practice rather than being currently involved in the experience which may have influenced the story or their perception of the story. Even though there was depth of the individual interviews, this study only examined seven female nurses' perspectives from the Midwest region of the United States. The nurses were demographically different in regard to experience, age and education but lacked diversity in broad geographical location, gender, religion and ethnicity.   The nurses interviewed represented nurses from various healthcare organizations within a tristate Midwestern area. The results of this study may be transferable to other critical care nurses in the Midwest but other populations need to be explored since values can change according to setting and geography.

We are unable to know about the nurses that chose not participate. The question arises that there may be internal conflict that exists that is preventing the non-participating nurses from discussing their experiences which will likely result in greater suffering. Nurses who are suffering from moral distress may negatively influence the healthcare environment by exacerbating the symptoms of moral distress leading to negative experiences for patients, their colleagues and the system as a whole. In addition, six of the nurses recruited in this study were from a professional organization demonstrating their involvement with advancing the

profession. We did attempt to recruit nurses by Facebook™. Posts from the AACN local chapter were made and shared multiple times by individuals with no participation from this source of recruitment. One nurse was recruited by word-of-mouth and agreed to participate because she "it is important to the profession" to tell these types of stories. Values and barriers may change according to varying demographic characteristics and involvement with professional organizations. Future studies will need to seek nurses who may not traditionally seek out these types of opportunities.

Nurses in this study relied on recalled experiences of moral distress rather than as the experience was occurring. Troubling was the details in which several nurses described their morally distressing experiences. In stories that ranged from very recent to up to 30 years prior, nurses could describe minuscule details such as what day of the week it was, what the patient looked like and odors in a room. Because these were recalled events, the influence of time and experience could impact detailing the experience.

Relevance to clinical practice

According to Raths, Harmin, and Simon (1966), values evolve and change over time and are dependent on societal norms. Similarly, moral recognition and moral actions are also based on individual values, which are fluid over the lifespan. In addition to individual morals, nurses are also guided by professional value statements such as the ANA *Code of Ethics*, which was recently revised in 2015. It is important for nurses, organizations and healthcare leaders to recognize current and specific values and barriers that facilitate moral distress. In order to

address this phenomenon and its impact on our nurses, patients and organizations, we must understand the fundamental value systems present and target interventions to lessen the detrimental impact of moral distress. Florence Nightingale professed the importance of human values over the scientific foundation of caring for individuals (Nightingale, 1992). The values and barriers identified in this study are a way to address specific targeted interventions aimed at moral distress.

Conclusion

Moral behaviors are based on values. Values lie at the core of human behavior and are expressed in our thoughts and actions (Rassin, 2008). The foundational premise of the phenomenon of moral distress lies within the moral values of the person. This in-depth, exploratory research with critical care nurses provides insight to the specific values and barriers present during moral distress experiences. Recognizing the barriers and values that are present may help to begin addressing specific interventions towards moral distress. Critical care professionals must identify and take steps to address moral distress (Morris & Dracup, 2008). "There is an urgent need for continued research that, even as we seek to refine and better understand moral distress, moves to identify interventions that decrease moral distress and protects the integrity of healthcare professionals" (Hamric, 2012, p. 47). This study identified specific barriers and values present in critical care nurses during moral distress patient care situations so that in the future we may begin to work towards better refinement of specific interventions deemed at lessening the impact of this phenomenon.

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Table 1

Values Definitions

Value	Definition
Accountability	To be answerable to oneself or other's
Advocacy	The act or process of pleading for, supporting, or recommending a certain course of action for persons or issues.
Altruism	The principle or practice of selfless concern for the well-being of others.
Autonomy	Respecting self-determined behaviors or decisions of individuals.
Beneficence	Benefitting others by preventing harm, removing harmful conditions, or acting on another's behalf.
Collaboration	Working cooperatively with others
Compassion	An awareness of suffering, combined with reasoning to relieve suffering
Competence	To exercise a level of skill, care or experience ordinarily possessed by a competent professional.
Courage	A virtue to enable a person to respond to a difficult or threatening circumstance; bravery.
Fidelity	Observance to promises, loyalty, fairness, truthfulness, accuracy, exactness in relationships.
Integrity	A cluster of attributes manifested as honesty, moral consistency and convictions to beliefs, knowledge commitments or obligations.
Justice	Equitable distribution of resources, social burdens and benefits to society.
Nonmaleficence	A duty not to inflict harm or balancing unavoidable harm with the benefits
Respect for persons	All persons should be treated with respect simply because they are human.
Responsibility	An obligation to perform required professional activities or act independently according to professional standards.
Self-regarding duty	Duty to self when self is the subject, object, and beneficiary of the duty.

Adapted from ANA Code of Ethics (2015)

Table 2

Barriers and Values in Moral Distress Experiences

Barrier	Value	Support statements
Falling short of personal expectations	Accountability Advocacy Altruism Compassion Integrity Fidelity Respect for persons Responsibility Self-regarding duty	"You know, I see it happening already and there's just dissatisfaction, disgruntlement and you can tell when you're around people who enjoy their job and it makes you enjoy your experience more [referring to care by a nurse] [accountability, responsibility]. You can tell when someone is being genuine with you and I feel like patients are going to start suffering because nurses aren't happy [advocacy, integrity]. It's really hard on the nurses [compassion] and then the nurses don't feel like they're giving good care [accountability]. I don't have time to turn a patient every two hours because I have to do my charting [responsibility]. The patient shouldn't not get turned because you have something else to do like charting [fidelity, respect for persons]. So they're being pulled in various directions [responsibility]. And tugging with do I turn my patient or do I get charting done so that I can leave at a decent hour once my 12 hour grueling shift is over [accountability, altruism, fidelity, integrity, respect for persons, responsibility, self-regarding duty]. "I think a lot of it occurred not only when I was the nurse, but also when I was the Charge Nurse; most of it was conflict that needed to be resolved or that because I was the Charge Nurse, I had to take care of [accountability], just different situations such as having too many patients or being in charge. One night I can think of, I was the most senior nurse on the floor, I was in charge, I had six patients and a new grad, she had only been out of school for 3-4 months. Her patient had a 3-way Foley [urinary catheter] that kept clotting and she couldn't keep it irrigated and I had to spend probably an hour just with her patient. That was an hour that I did not seen any of my patients [fidelity, responsibility]. It was just how do I take care of my patients? [accountability, fidelity] How do I teach her; it was my

		responsibility as Charge Nurse to make sure she was o.k., and she wasn't o.k. and didn't know how to handle it [advocacy, integrity, responsibility]. I felt responsible to the other nurses as their leader [altruism] and those roles are in conflict if there is not enough of you to go around for all of them."
Inadequate training, preparation, education or mentoring (either to mentor or be mentored)	Accountability Altruism Beneficence Collaboration Competence Courage Fidelity Justice Nonmaleficence Responsibility	"We did have some new nurses who I thought were very good for being on that unit [collaboration]. Seemed like they learned fast. But we would pull [cardiac] sheaths [on the unit] so these new nurses who would come in they weren't teaching them how to do them [advocacy]. They told them they had to be on the unit a while before they would teach them that [accountability, competence]. There were actually days where no one was on the unit where we were able to pull a sheath [competence, justice], so the cardiologist would have to make the Cath Lab people stay to pull the sheath and they weren't happy about that [responsibility]. But that is all they could do. Why would only one person be here who can pull a [cardiac] sheaths? [nonmaleficence, responsibility] Why not take these new ones [nurses] and teach them how to pull a sheaths? [advocacy] They wanted them to learn in the Cath Lab and go to the Cath Lab and do it. But, then they would never let them go" "You had to do it [a dressing change] under sterile procedures. I was emphatic because I knew it was a high risk procedure and the nurses were not trained [accountability, beneficence]. They [leadership] did not embrace competence [competence, fidelity]. It did not bother them that all the nurses lacked a standard of basic knowledge. They were a warm body. They filled the hole. I was the educator. I was bound and determined that this 35-year-old patient, for any strength of power in me, that he was not going to get an infection from my watch or from anybody I trained [courage, fidelity, nonmaleficence]. I'm just going to make sure that he's safe." [accountability, altruism]

| Insufficient organizational support | Accountability
Advocacy
Beneficence
Compassion
Justice
Nonmaleficence
Respect for persons
Responsibility
Self-regarding duty | "This physician we work with day in and day out in the ICU, he was one of the regulars so you see him all the time. The last thing you want to do is create bad blood and have it just be a bad day every time you work with them [self-regarding duty]. So it's just really uncomfortable to try to stick up for what you believe is right. [advocacy, beneficence, justice]. We got the manager and the supervisor involved [advocacy, collaboration]. They were on our side and unfortunately it was just one of those situation where he [the physician] said we could only increase the morphine so far [for a patient she believed was suffering] [accountability, advocacy, compassion, nonmaleficence]. And so it's kind of -- they [leadership] threw their hands up at it [responsibility]. So I didn't feel like there was as much support there because they're like, well, you know, you can't make them [the physician] too angry."[accountability, justice]

"I think the changes in healthcare are really hard on nurses [justice]. The patient satisfaction is how we get paid and do more with less, work harder, work faster, and do it with a smile and there's so much being asked of bedside nurses that everything, you know, shit rolls downhill and it all lands on the nurse [accountability, justice, respect for persons]. [For example] The doctor doesn't do his charting. You do the charting for him [accountability, integrity, responsibility]. The doctor doesn't order this, you call and ask him to order it because you got to meet your core measures so that they don't come back readmitted for heart failure in 30 days because if they do that then you don't get paid for their admission, so then there's going to be no money left for you for raises at the end of the year [accountability, beneficence, responsibility, self-regarding duty]. You know, patient satisfaction."

"I had a patient try to hit me in the middle of the night and per institutional policy if there is a situation like that you are supposed to call the police [the hospital had their own police department] [beneficence, responsibility]. My supervisor contacted the patient and discussed the |

		situation to see what needed to happen from there and she [the supervisor] would not let me call the police [collaboration, responsibility]. So, just by what should have happened and what happened, it ended up that it turned into a huge ordeal. She went to talk to my boss about it the next morning and my boss was in agreement that this would have not been the correct situation because they decided it was more important that the patient be happy and not be confronted than having to call the police and upset the patient, this is what kept being said [advocacy, collaboration, responsibility]. It ended up I did have to go to the police in the morning because the patient was in a semi-private room and the patient in the other bed was a retired police officer and he heard the conversation in the hallway with me and the nursing supervisor; he was in the room with the patient when he said what he said and did to me [advocacy, respect for persons]. He went and filed his own police report because he felt that I was being wronged [altruism]. Then, I had to go and file one as well. I was upset the whole rest of the shift because these are people that are supposed to believe me and trust me-they work with me and if this happened to them this is not how I would have reacted." [advocacy, collaboration, fidelity, respect for persons, responsibility].
Untrusting relationships with nurse colleagues	Advocacy Beneficence Collaboration Compassion Integrity Nonmaleficence Respect for persons Responsibility Self-regarding duty	'She's [a nurse colleague] over aggressive. She's very opinionated, regardless of whether it's policy or research-based or anything, what the way she does it is smarter, better, wiser. I would avoid interactions with her mostly. My reports are very effectual and not conversational. We'd be planning a committee meeting for something and she wanted to be involved and because we don't want her to volunteer, we wouldn't tell her about it." [collaboration, respect for persons, responsibility, self-regarding duty] "They're cruel [referring to a nurse colleague] [compassion]. Sometimes they're flat out cruel. Patients with dementia who are constantly pulling at tubes and wires because first of all they're demented [beneficence].

		Second of all, they're probably suffering a disease process that makes that more complicated. They sometimes yell at them or threaten restraints. I mean that's fricking like off the wall [advocacy, compassion, respect for persons]. It's awful to do to a person. Let me strap you down because you don't understand what's going on and all you're doing is going on instinct. That's wrong on so many levels, but that's all they know sometimes [advocacy]. But I don't know that these nurses that do this consistently would even be receptive [to change their behavior]." [beneficence, compassion, integrity, responsibility, respect for persons]
Inappropriate or controlling actions or behaviors of non-nurse providers	Accountability Advocacy Collaboration Compassion Competence Courage Fidelity Integrity Justice Nonmaleficence Respect for persons Responsibility Self-regarding duty	"[nurse recalling a conversation with a physician] So you're telling me that if this patient goes into V-tach you're expecting me to do something that I'm not qualified to do [out of scope of nursing practice] and he goes well, if you don't, I'll tell the family that you caused their death." [collaboration, competence, nonmaleficence, responsibility, self-regarding duty] "Another example of the difference between nursing and medicine and where I feel like medicine, especially older physicians, they're trained that death is failure [competence, integrity]. And that, we should fight death to the last tooth and nail, whatever we can do so the patient doesn't die and nursing is taught keep the patient comfortable [advocacy, compassion, responsibility] . The only sure way to die is to be born because we're all going to die [responsibility]. The least we can do is make a dignified comfortable situation." [advocacy, compassion, responsibility] "I think it was about the doctor getting aggressive with the family and then with the other doctors, even though there was already a conversation he wasn't a part of an agreement to understand what was going on with her, he got the Savior complex. [accountability, advocacy, compassion]. 'Well, you guys said you were -- I can do something. I can fix this.' Then he kind of got the family member on board and against the RNs and saying that oh, the 'RNs just want to pull the plug', and then there was no pain

control [collaboration, responsibility]. And a couple of nurses, myself and another nurse really had gotten upset because we're like 'you're not at her bedside 24/7' [accountability, fidelity, nonmaleficence]. 'You're not seeing the look on this woman's face to know' [compassion, respect for persons, responsibility]. I mean she is in pain. She's dying of cancer. She's got metastases in her bones. So the charge nurse and the nursing supervisor got involved and they called the physician who had said no narcotics [accountability, collaboration, courage]. He said I feel like you're gaining 'ganging up on me' [collaboration]. Your nurses need to be professionals and leave their emotions at the door. If you want, I will transfer the patient to the other ICU. I'm concerned about the patient's hemodynamics and keeping the patient alive for the family wishes, and even when we started the morphine drip, he wouldn't let us turn up what we thought was adequate [compassion, responsibility]. You could increase it two milligrams every four hours, which was not our standard. Our standard was much more aggressive in that end-of-life [compassion, responsibility], but it was just to have him tell us to leave our emotions at the door and to have us tell him that like we're ganging up on him because he's trying to keep someone alive for the family's wishes, even though that's not really what the family's wishes were [advocacy, fidelity, nonmaleficence]. It was just a really uncomfortable situation where we're like, you know, you start to second-guess yourself." [accountability, self-regarding duty]

"It's just a tug and pull where the nurse is saying please keep my patient comfortable and the doctor is saying don't kill my patient. I'm like well, they're dying. We're not killing them. The cancer is killing them. I mean, you know, we've already reached that point." [advocacy, collaboration, responsibility]

"Is there one that gets more power or that tends to win?--a physician [collaboration, self-regarding duty]. I think when it comes down to families, its white coat and the males and the doctor. They listen to

		whatever the doctor says. You know, I just take whatever the doctor tells me to take and there is still that pedestal that doctors are held on. Rightly so. Some of them are amazing people, but they're people. They're not perfect and they're held on such a pedestal and there's just so little knowledge amongst laypeople, nonmedical people about what end-of-life is like and the family said well, that's what the doctor wants [advocacy]. So --They don't know what they want because they're so upset that they just tend to gravitate towards whatever the doctor says [accountability, advocacy, beneficence, respect for persons]. I mean I think in a lot of these situations they're [the families] beside themselves [altruism]. I mean how can you -- I can't even imagine having a family member dying in the ICU and okay, so do you want to die today or should we wait until tomorrow? [compassion] I mean it's like, it's huge, and I think it's very easy for anyone who works in that location for any period of time, whether it be physician or nurse to forget what it could be like on the other side [advocacy, compassion, fidelity, respect for persons]. We see patients die every couple of days. We see patients really sick. We see naked people. We see tubes. We see drains. We forget how scary that looks from the other side [advocacy, compassion, fidelity, justice, respect for persons]. They're in shock and someone in white shows up, to save the day even if the actions aren't right."

Table 3

Participant Demographics

Category	Classification	*n = 7*
Age	20-30 years	1
	31-40 years	3
	41-50 years	0
	51-60 years	2
	61+ years	1
Gender	Male	0
	Female	7
Race/Ethnicity	Non-Hispanic White or Euro-American	6
	Black, Afro-Caribbean, or African American	1
Religion	Christian	7
	Others	0
Highest level of education	Diploma	0
	Associates	0
	Bachelors	4
	Masters	3
	Doctoral	0
Years as Professional Nurse	Less than 3 years	1
	3-5 years	0
	5-10 years	2
	10 to 15 years	1
	15 to 20 years	0
	20 to 30 years	1
	30 years	2
Types of specialty critical care experience	Neonatal	0
	Pediatric	0
	Medical	5
	Surgical	5
	Preoperative, Operating Room, or Postoperative units	1
		-
	Emergency Room	1
	Progressive Care Units	4
	Other	2

CHAPTER FIVE

CONCLUSION

Working in the acute care hospital setting can lend itself to barriers for acting in a manner that is morally right for the individual health care practitioner. When a nurse encounters moral and ethical situations that prevent them from acting in what they feel is the best course of action for a patient to achieve optimal health outcomes, it can lead to distress. A painful, psychological disequilibrium can result from a single, severe encounter or multiple distressing situations that are presented frequently (American Association of Critical Care Nurses [AACN] 2005; Wilkinson, 1987). This disequilibrium in health care practice has been named moral distress and studied extensively in nurses working in intensive care units.

Moral Distress can lead to suffering. In a nurse, moral distress can manifest itself with feelings such as frustration, anger, anxiety, guilt and physical reactions such as sweating, shaking, headaches, diarrhea and crying (Burston & Tuckett, 2013; Jameton, 1993; Wilkinson, 1987). Nurses have described moral distress situations as "torturing patients" and "emotional pain" (Popejoy, Brandt, Beck, & Antal, 2009, p. 184), "suffering" (Edison, Lerch Lunardi, Lerch Lunardi, Geri Tomaschewski-Barlem, & Rosemary, 2013, p. 284), "horror and dread" (Hanna, 2005), and emotional exhaustion (Meltzer & Huckabay, 2004). Unrelieved moral distress threaten a nurse's sense of self-worth, character and integrity (Rushton, 2006). Moral distress can result in nurses feeling powerless resulting in job dissatisfaction, resignation, burnout, and/or distancing oneself from patients and families (McClendon & Buckner, 2007; Meltzer & Huckabay, 2004; Rice et al., 2008).

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The cost of moral distress reaches beyond the financial costs to replace a nurse in an organization, but more so lies in the price of quality patient care and its impact on the organization. Moral stress was a statistically significant predictor of increased employee fatigue, decreased job satisfaction, and increased turnover (DeTienne, Agle, Phillips, & Ingerson, 2012). Fatigue and low job satisfaction leads to increased turnover and high rates of burnout which was found to be significant in hospital cases where rates of hospital-acquired infections were high (Cimiotti et al., 2012). Moral distress has implications for the safe delivery of optimal healthcare and impacts nurses' satisfaction, retention, and recruitment.

Despite having substantial work to support its existence, interventions for moral distress are less developed. Lessening the impact of moral distress begins with a nurses' ability to recognize and name this experience as morally distressing and organizations committing to tangible, targeted interventions (AACN, 2008). Hanna (2004) notes nurses are able to consistently describe elements of moral distress even though they may be unable to name them as moral distress events. Several studies have reported nurses rating themselves as having absent to low levels of moral distress, but then described situations that were morally distressing (Hanna, 2004; Ruggiero, 2005; Wilson et al., 2013). The nurses' recognition and impact of moral distress varies much like the various situations that cause moral distress. Half of all nurses in a study by Solomon et al. (1993) stated they acted against their own consciousness while providing care and that this caused them distress. Interventions to reduce or eliminate the effects of moral distress have been limited due to the complexity of the situations and the various effects of moral distress on people

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and organizations.

Early on in my doctoral program, the purpose of this dissertation was to identify and test an intervention for moral distress. The study described in Chapter 2 left me with the question of "what do we do about this"? I started by examining prior literature and completing a theory analysis of the most widely utilized theory for moral distress (Chapter 3). This resulted in revealing gaps that needed to be addressed prior to interventional research being initiated. Specific and targeted interventions had to address the dynamic interpersonal and institutional relationships that are present in healthcare encounters where moral distress exists. The main dissertation project (Chapter 4) attempts to identify the key variables that a nurse perceives to exist in moral distress encounters. These variables include the perceived barriers and values during patient care situations with which moral distress is present. Extrapolating the nurse's perception of interpersonal and institutional barriers and values may hold the key to identifying effective interventions for moral distress (Musto et al., 2015).

Midway through my doctoral program, a grant was submitted to create multi-segment factorial video vignettes displaying moral distress patient care scenarios. Doctoral of Nursing Practice (DNP) students were proposed to create the storylines since they are often experienced nurses with a wealth of clinical expertise and are relatable to the staff nurse. As a part of the moral distress video vignettes, bedside nurses would first be led to recognize moral distress in simulated patient care scenarios and then transverse the scenario that would likely lead to a moral distress encounter with prompts to attempt to find moral comfort or resolve. The ultimate goal of the project was to use these

simulated videos in future interventional studies to determine if the intervention could provide a moral exemplar and teach nurses to recognize and positively change future encounters based upon the stimulating, interactive vignettes. Even though the grant funding was not supported because according to reviewers, it lacked an interdisciplinary focus as outlined in the grant requirements, the scenarios were developed with the DNP students for future work. As a result of this work, subsequent discussions occurred with the Office of Technology Management and Industry Relations at the University of Missouri. We explored patentability and copyright of our moral distress video vignettes. Although no further work evolved from these efforts, the foundation for future intervention work on the topic was gained. This project helped me to examine the scenarios that skilled expert nurses would create when given the opportunity to address moral distress, intricately identify the processes that are necessary for scenario development and learning about safeguarding an intellectual idea.

Another project that was addressed within my doctoral work and integrated into this dissertation project was an Institution Review Board approved secondary analysis of the open-ended responses to questions about moral distress situations in a previously published study (Chapter 2). Even though nurses responded to the quantitative scale with relatively low levels of moral distress, their open-ended responses seemed to indicate a higher intensity (Wilson et al., 2013). We attempted to perform a descriptive grounded theory methodology to identify if a theory could be generated that explained or predicted moral distress based upon their responses. Since this study was retrospective and availability of data was limited to what was

already recorded, the study was revised utilizing a qualitative thematic analysis approach. Themes and values were found and categorized according to the Moral Distress Theory (Corley, 2002) and the American Nurses Association (ANA) *Code of Ethics for Nurses* (2015). The study findings remain unpublished but were presented at a professional nursing conference. The results of this study helped to form the research questions and methodology to be used in a subsequent study (Chapter 4).

Chapter four evolved from previous work completed and attempted to identify specific values and barriers present in critical care nurses during moral distress experiences. Main analysis findings demonstrated specific values and barriers present during moral distressing encounters in seven critical care nurses. Findings from this study highlighted the dynamic relationship of the nurse to interpersonal and institutional aspects of healthcare encounters and the barriers and values involved in moral distress encounters. Future studies may attempt to identify specific interventions to target these barriers and values identified.

Limitations of this study included the lack of broad demographically diverse nurses. Nursing professional ethical obligations are detailed in the ANA *Code of Ethics* (2015) and recently revised to more accurately reflect the ethical obligations of the profession. Morals or values are more subjective and personal. Values are both personal and influenced by society and/or the social group (Weis & Schank, 2000). The findings that evolved in this study will need to be repeated in a broad geographical area with a diverse sample to ensure an accurate depiction of moral distress values and barriers. In addition, future work will need to see if the values identified in this study align with the

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recently revised ethical guidelines of the profession.

Despite these limitations, this comprehensive doctoral work will assist to move the science in this area forward. Moral distress is a part of the everyday existence of a nurses' experience. Moral distress can be a positive catalyst that may prompt nurses to act when they may not have initially, but often it is not recognized until its impact is advanced and masked as something else like a nurse with a bad attitude or a nurse that never gets involved with anything happening on the unit (Hanna, 2004; Ruggiero, 2005; Wilson et al., 2013). Unfortunately, very little effort has been put forth to make great strides in lessening the impact or preventing moral distress; rather organizations are left cleaning up the mess from it. The AACN issued a position statement in 2008 that stated healthcare organizations need to put forth resources towards the recognition and lessening the impact of moral distress (AACNb, 2008). Most organizations seem very interested in providing optimal healthcare conditions but have little direction in doing what will be meaningful at improving recognition or lessening the impact of moral distress.

Future work has already begun for me to continue the efforts towards effective interventions for moral distress. Recently, I received federally funded support for a study that will evaluate the presence of moral distress in military healthcare practitioners that transport our injured service members during flight from combat and peacetime missions. These critical care transport teams can be flying with critically injured service members or even enemy combatants for extended periods of time in austere flight conditions. If moral distress is present in these military healthcare practitioners, we will conduct future studies that attempts to lessen its impact on our military personnel. This

information will likely be transferable into our civilian healthcare

environments.

APPENDICES

Appendix 1

Permission letter AACN

February 9, 2015
American Association of Critical Care Nurses
Greater Cincinnati Chapter
P.O. Box 19122
Cincinnati, Ohio 45219

Melissa A. Wilson, PhD(c), MSN, APRN, CCNS-BC
3779 N. Taylorsville Rd.
Hillsboro, Ohio 45133

Dear Ms. Wilson

The American Association of Critical Care Nurses, Greater
Cincinnati Chapter is writing this letter to support our
involvement with your study entitled "Values and Ethics in
Moral Distress Stories". Once approval is gained through the
University of Missouri's Institutional Review Board (IRB), the
AACN leadership for the AACN-GCC chapter agrees to allow
you to recruit local AACN members for participation in this
research study. For the study, you have our permission to use
our Facebook page, website announcements and mini board
meetings before workshops to announce your study for
recruiting participants. The AACN will support your
recruitment of 10-15 experienced critical care nurses, who are
AACN-GCC members, to talk about their experiences with
moral distress. No financial support will be given from the
organization for this study proposal. AACN National Chapter
Specialist, Karen Certalic is also supportive of this research
study and our local chapter participation.
Once IRB approval is granted, please send us a definitive
recruitment plan. We look forward to working with you to
address this important issue to nurses in critical care.

Thank you,

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Informed Consent Chapter 4 study

WAIVER OF DOCUMENTATION OF CONSENT

INVESTIGATOR'S NAME: MELISSA WILSON

PROJECT #

STUDY TITLE: BARRIERS AND VALUES OF MORAL DISTRESS AMONG CRITICAL CARE NURSES

1. I would like to ask you to participate in a study that involves research.
2. Participation is voluntary and your decision not to participate will not involve any penalty or loss of benefits.
3. For this study, you will be asked to discuss your experiences with moral distress that have occurred in clinical practice. This discussion can be as long as you would like to discuss the topic and can be stopped at any time by requesting to stop with the interviewer. This interview will be audio recorded. At the end of the interview, you will also be asked a few questions regarding your personal information like years' of experience as a nurse and highest completed education level. The demographic form should take no longer than 15 minutes to complete.
4. The purpose of our study is to learn about your clinical practice experiences so that we can attempt to improve your work environment.
5. We are asking approximately 15 subjects to participate in this study.
6. The study staff may withdraw you from the study at any time after explaining to you the reason for withdrawal.
7. We are not aware of any risks to you if you decide to participate in this study. You may experience some uncomfortable feelings with answering the questions or discussing these experiences. At the end of the interview, information for employee assistance programs through your employer or private insurance will be advised if needed... You should discuss any of these needs with the investigator if they occur.
8. If you agree to take part in this study, aggregate results of this study will be shared at a local American Association of Critical Care Nurses (AACN) board meeting. The results will also be submitted for the principal investigators' dissertation project and for publication in a nursing journal once compiled and analyzed. No individual or facility specific information will be shared. Your participation will benefit future research in managing distressing patient care situations. You may expect to benefit from taking part in this research to the extent that you are contributing to medical knowledge
9. If you choose to participate, information produced by this study will be stored in the investigator's locked file and identified by a code number only. The code key connecting your name to specific information about you will be kept in a separate,

secure location accessible only to the investigator. Information contained in your records may not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law.

10. There is no cost to you except for expenses related to travel and time which will be your responsibility and not reimbursed by this study.

11. There is no compensation given to you for participation in this study.

12. It is not the policy of the University of Missouri to compensate clinical research subjects in the event the research results in injury. The University of Missouri, in fulfilling its public responsibility, provides medical, professional, and general liability insurance coverage for any injury in the event such injury is caused by the negligence of the University of Missouri, its faculty or staff. The University of Missouri also will provide facilities and medical attention to subjects who suffer injuries while participating in research projects at the University of Missouri.

13. If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may contact the University of Missouri Health Sciences Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-3181.

14. If you have any problems or questions, you may contact Melissa Wilson @ 513-313-0130 or by email at maw5r5@mail.missouri.com .

15. I would be happy to answer any questions that you may have.

16. A copy of this script will be given to you to keep.

Appendix 3

Demographics form Chapter 4 study

Please respond to the following questions.

1. Circle your corresponding age: 20-30 years

        31-40 years

        41-50 years

        51-60 years

        61 and greater years

2. Circle your gender: Male or Female

3. Do you have a religious affiliation?   YES or NO or don't know

      If yes, please circle the religious affiliation that you most closely

associate with:

        Christian

        Jewish

        Buddhist

        Muslim

        Hinduism

        Not listed

        Unaffiliated

        Choose not to identify

4. Circle the highest level of education completed:

        Diploma

        Associates

        Bachelors

        Masters

Doctoral

5. How many years have you been a professional nurse?

Less than 3 years

>3-5 years

>5-10 years

>10 to 15 years

>15 to 20 years

>20 to 30 years

>30 years

6. Please identify the types of specialty critical care units that your experience as a

professional nurse has occurred (circle all that apply).

Neonatal

Pediatric

Medical

Surgical

Preoperative, Operating Room, or

Postoperative units

Emergency Room

Progressive Care Units

Other

Appendix 4

Interview guide Chapter 4 study

<u>Introduce researcher</u>: Hello, my name is Melissa Wilson and I am a local member of the American Association of Critical Care Nurses-Greater Cincinnati Chapter. I am a student at the University of Missouri, completing my PhD in Nursing and the primary researcher on this study, which is part of my work for my dissertation. Thank you for taking the time to talk with me today about the issue of moral distress in nurses.

<u>Initial open-ended questions (all participants):</u>

1. Please tell me about where you currently work.
2. Is this the same place you worked when you experienced moral distress?

<u>Intermediate questions (select questions):</u>

3. Please describe the morally distressful situation that you experienced. What did you do about that experience?
4. Tell me what you were thinking and feeling at that time? What happened next?
5. Describe how others responded.
6. In this particular example (above), describe whether you felt what you were doing (or refraining from doing) was morally right or wrong.
7. Were there particular values or commitments that you felt you were acting against, or wanted to act on behalf of, but were prevented from doing so?
8. Help me to understand where these values come from. Sometimes personal beliefs are derived from parents, religion, institutional values or commitments that the organization had articulated, how do think that each one of these influenced your experience of moral distress?
9. As you look back on the event you described, are there any other situations that occurred that made you feel similar? Could you describe one [each on]? How did this event affect what was happening? How did you respond to the event? IF named, repeat ?'s #6-8 for each.
10. Tell me how you learned to handle these or similar experiences.
11. How have your thoughts changed about your job since this experience?
12. How have aspects of these experiences stay with you after leaving work?
13. What positive changes have taken place in your work and personal life since these events?
14. What negative changes have taken place in your work and personal life since these events?

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15. How do you feel today about these experiences? Describe how, if any, you personally or your practice has changed since these events?
16. What helps you to manage Moral distress? What problems might you encounter when trying to manage Moral distress? What is the source of these problems?
17. Describe the most important lessons [if any] you learned through experiencing moral distress?
18. Who has been the most helpful to you during this situations? Describe how these persons were helpful.
19. Who has not been helpful during these situations? Describe how they were not helpful?
20. Besides your individual experiences, what else do you know about moral distress?

Ending questions (select questions):

21. Based on your experiences, describe the most important way to prevent moral distress.
22. Tell me about advice that you would give other nurses about moral distress.
23. Is there anything you would like to ask me?

Close (all participants):

Is there anything else that you would like to share?

Thank participant for participation. Close interview. Stop recording.

If needed during the interview, the standard definition for moral distress will be given as follows:

"Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of a real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong" (Nathaniel, 2006, p. 421).

Adapted from Charmaz (2014)

Appendix 5

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VITA

Melissa Wilson's claim to fame began at birth by being the largest baby ever born at Los Alamitos General Hospital in the 1970's. Coming from a saintly mother and a father in the Navy, living and traveling abroad began at an early age. With one older brother gifted at keeping Melissa grounded in humility combined with her experiences in foreign countries, Melissa gained an appreciation of overcoming difficulties to achieve optimal experiences. In high school, her parents moved from coastal California to rural Appalachian town, USA. After high school graduation, Melissa moved away to complete a Bachelor's of Science in Nursing (BSN) program at a metropolitan university. She then returned back to her small town to raise children and this is where she currently resides. Melissa worked in various specialty areas within acute and critical care as a BSN prepared nurse until she agreed to teach one clinical course at her alma mater nursing school. From there, she was hooked and nursing education became her livelihood for the next seven years rising through the ranks to Associate Director of the

Undergraduate Nursing program at a local university. In addition, Melissa completed her Master's in Nursing and is certified as a Clinical Nursing Specialist with critical care expertise and a nurse educator focus. It was during this program that moral distress became a research interest. Seeking more involvement in research, Melissa began her PhD in nursing program in 2012 at the University of Missouri through a distance-mediated program. In 2013-2014, Melissa was selected to serve on the American Nurses Association Code of Ethics for Nurses Revision Panel as an Advisory Committee Member. In addition, a certification in health care ethics was obtained concurrently. In 2014, Melissa was hired as a contracted Nurse Scientist for the United States Air Force School of Aerospace Medicine where she continues to focus her research endeavors on moral distress, pain management and the use of healthcare technologies in military healthcare practitioners. Melissa continues to live in rural Appalachian town USA with her husband, two children, four dogs, two cats, two parents, one brother and sketchy Wi-Fi.