DEVELOPMENT AND PILOT TEST OF A CONSCIENTIZATION INTERVENTION FOR NURSES WHO HAVE EXPERIENCED MORAL DISTRESS

A DISSERTATION IN Nursing

Presented to the Faculty of the University of Missouri-Kansas City in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

by

NANCY BEVAN

BSN, University of Cincinnati, 1980
MSN, University of Cincinnati, 1988

Kansas City, Missouri
2019
DEVELOPMENT AND PILOT TEST OF A CONSCIENTIZATION INTERVENTION FOR NURSES WHO HAVE EXPERIENCED MORAL DISTRESS

Nancy Ann Bevan, candidate for the Doctor of Philosophy degree

University of Missouri-Kansas City, 2019

ABSTRACT

Nurses act as moral agents for patients and use their moral sensitivity to build trusting relationships to act in patients’ best interests. However, nurses also lack power in their place of employment due to inequality in power relations. When this lack of power interferes with being a moral agent, moral distress occurs. Moral distress can lead to burnout and leaving the profession. In this dissertation, I sought to learn whether an intervention, guided by the principles of conscientization developed by the Brazilian philosopher and educational theorist Paulo Freire in his classic work, Pedagogy of the Oppressed, would be acceptable and feasible with nurses who had previously been exposed to moral distress.

An interactive small-group intervention in three sessions was developed and piloted with 13 nurses within four different types of critical care units from three different hospitals. Pre-and post-intervention surveys were administered to measure change in psychological empowerment, structural empowerment and moral distress levels. Open-ended interviews were conducted at two weeks post-intervention to assess acceptability and feasibility, as well as the nurse’s sense of personal empowerment post-intervention. The pilot study demonstrated that the conscientization intervention is feasible and acceptable to participants.
Narrative analysis of the moral distress stories revealed themes of powerlessness experienced by nurses in interactions with families, organizations, and physicians.

Evaluation of goal attainment from each session revealed increased empowerment during the movement through the sessions of critical reflection, critical motivation, and critical action. Post intervention interviews indicated that nurses perceived that they gained an increased understanding of moral distress and a sense of personal and group empowerment after the intervention. Survey results showed a significant decrease in moral distress mean and frequency, a significant increase in moral distress intensity, and no significant change in mean levels of psychological or structural empowerment post intervention. The pilot study demonstrated that a conscientization intervention formulated around critical reflection, motivation, and action and delivered in a small-group format with nurses is a feasible and acceptable way to reduce moral distress levels and develop personal empowerment. Reducing moral distress among nurses is crucial for reducing burnout, improving retention, and improving patient care.
The faculty listed below, appointed by the Dean of the School of Nursing and Health Studies, have examined a dissertation titled “Development and Pilot Test of a Conscientization Intervention for Nurse who have experienced Moral Distress,” presented by candidate Nancy Ann Bevan, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

Supervisory Committee

Amanda M. Emerson, Ph.D., Committee Chair
School of Nursing and Health Studies

Jennifer L. Hunter, Ph.D.,
School of Nursing and Health Studies

An-Lin Cheng, PhD,
Department of Biomedical and Health Informatics
School of Medicine

Elizabeth Epstein, PhD
University of Virginia School of Nursing
Professor

John Lantos, MD.
Department of Pediatrics
School of Medicine
Children’s Mercy Hospital

John Lockhart, PhD
Director, Freire Institute
University of Central Lancashire
United Kingdom
CONTENTS

ABSTRACT .................................................................................................................................................. iii

LIST OF TABLES ........................................................................................................................................ xiii

LIST OF ILLUSTRATIONS ....................................................................................................................... xv

ACKNOWLEDGMENTS .............................................................................................................................. xvi

Chapter

1. INTRODUCTION ................................................................................................................................... 1

   Study Purpose and Specific Aims .................................................................................................................. 5

   Definition of Terms ......................................................................................................................................... 6

   Assumptions and Hypotheses ....................................................................................................................... 9

2. REVIEW OF LITERATURE ...................................................................................................................... 10

   Introduction ................................................................................................................................................... 10

   Ethical Origins of Moral Distress in Nursing .............................................................................................. 10

   History and Conceptualization of Moral Distress ....................................................................................... 11

      Jameton to Campbell: Conceptualization to Operationalization ......................................................... 12

   Moral Distress in Nursing ............................................................................................................................ 19

   Scope of Moral Distress ............................................................................................................................... 20

   Sources of Moral Distress ............................................................................................................................. 20

      Group One: Futile Care/Euthanasia

      Circumstances Related to Clinical Situations ......................................................................................... 21

      Group Two: Deception/Physician Practice/

      Nursing Practice Dimension Factors Internal
to the Individual and Professionals ................................................................. 23

Group Three: Institutional/Work Climate

Factors Present in Unit Culture/ Institutions and Health Care Environment at Large ................................................................. 25

Behavioral Responses to Moral Distress .......................................................... 30

Physical and Psychological Consequences ...................................................... 30

Effect on Patient Care .................................................................................. 31

Effect on Nurse Retention and Burnout ......................................................... 31

Multidisciplinary Moral Distress ..................................................................... 33

Measurement of Moral Distress ..................................................................... 35

Interventional Research for Moral Distress ...................................................... 38

The Literature on Power, Empowerment, and Oppression ............................... 44

Power ............................................................................................................. 44

Empowerment ............................................................................................... 48

Oppression ..................................................................................................... 49

Anne Cudd and Social Oppression ................................................................... 50

Oppression in Nursing .................................................................................... 51

Sequencing of Oppression in Nursing ............................................................ 51

Iris Young and the Five Faces of Oppression .................................................. 55

Oppressed Group Behaviors ......................................................................... 59

Oppressed Group Behaviors in Nursing .......................................................... 60

Linking Moral Distress, Power, Oppression ..................................................... 63

Theoretical Framework ................................................................................... 64
Oppression and Paulo Freire ........................................................................................................ 65
  Pedagogy of the Oppressed ................................................................................................. 66
Role of the Animateur .............................................................................................................. 68
Problem Posing Education ..................................................................................................... 69
  Learning Stages ..................................................................................................................... 71
Conscientization ...................................................................................................................... 73
Summary .................................................................................................................................. 74
3. METHODS .......................................................................................................................... 76
  Development of the Intervention .......................................................................................... 76
  Four Stage Model for Problem-Posing ................................................................................ 77
  Conscientization Educational Sessions ............................................................................. 78
    Session One: Critical Reflection ...................................................................................... 79
    Session Two: Critical Motivation .................................................................................... 82
    Session Three: Critical Action ......................................................................................... 84
  Research Design ................................................................................................................... 86
  Qualitative Measures .......................................................................................................... 87
  Quantitative Measures ......................................................................................................... 88
  Recruitment Strategies ........................................................................................................ 91
  Sample .................................................................................................................................. 92
  Setting .................................................................................................................................. 93
  Institutional Review Board .................................................................................................. 93
  Protection of Human Subjects ............................................................................................. 94
  Procedures ............................................................................................................................ 95
Three-Session Educational Intervention.................................................................................. 95
Post-Intervention Interviews................................................................................................ 98
Total Mixed Methods Data Analysis.................................................................................... 100
Mixed Methods Data Analysis: Aim 2 .................................................................................. 100
Mixed Methods Data Analysis: Aim 3 .................................................................................. 101
Qualitative Analysis............................................................................................................. 102
  First Data Source .............................................................................................................. 102
  Second Data Source ......................................................................................................... 105
  Third Data Source ............................................................................................................ 106
Quantitative Data Analysis................................................................................................... 106
Convergence ....................................................................................................................... 108
Reflexivity .......................................................................................................................... 109
4. RESULTS .......................................................................................................................... 111
Demographic Data .............................................................................................................. 111
Aim 2: Feasibility and Accessibility..................................................................................... 112
Aim 3: Impact of Conscientization Intervention .................................................................. 116
Moral Distress Stories......................................................................................................... 116
  Thematic Analysis Results ............................................................................................... 117
  Structural Analysis Results ............................................................................................. 122
Aim 3: Three Group Sessions.............................................................................................. 124
  Session One: Critical Reflection ...................................................................................... 124
    Learning Stage: Understanding Ourselves ..................................................................... 125
    Learning Stage: Understanding what Already Exists .................................................... 126

Learning Stage: Weighing Options ................................................................. 128
Session Two: Critical Motivation................................................................. 129
Journal Article Review ............................................................................. 129
Learning stage: Understanding Where We Wish to Go ............................. 132
Session Three: Critical Action................................................................. 134
Journal Article Review ............................................................................ 134
Learning Stage: Strategy Building, Planning, Resource-Acquisition ........... 136
Learning Stage: Action Projects ............................................................... 138
Aim 3: Post-Intervention Interviews ......................................................... 140
Quantitative Data Source ......................................................................... 152
Aim 2: Feasibility and Acceptability ......................................................... 152
Aim 3: Impact of a Conscientization Intervention ....................................... 153
Effect of Intervention ............................................................................... 162
Convergence of Data ............................................................................... 165

5. DISCUSSION ......................................................................................... 171
Participants in the Study .......................................................................... 171
Feasibility and Acceptability .................................................................. 173
Components of Moral Distress Stories ....................................................... 175
Sources of Moral Distress ....................................................................... 175
Response of Nurse ................................................................................... 175
Power Dynamics ..................................................................................... 176
Impact of Intervention—Taking Action to Change................................. 177
Limitations......................................................................................... 183
Implications for Future Research....................................................... 184
Implications for Practice................................................................. 185
Conclusions...................................................................................... 187

Appendix

A. Session One Tool “Understanding Ourselves”................................. 189
B. Session One Tool “Understanding What Already”............................ 190
C. Session One Tool “Weighing Options”.......................................... 191
D. Schematic for Session One............................................................... 192
E. Session Two Tool “Understanding Where We Wish to Go”.............. 193
F. Schematic for Session Two............................................................... 194
G. Session Three Tool “Strategy Building”.......................................... 195
H. Session Three Tool “Action Project Template”.............................. 196
I. Schematic Session Three................................................................. 197
J. Demographic Tool.......................................................................... 198
K. MDS-R Tool.................................................................................. 199
L. MDS-R Tool Permission................................................................. 201
M. Psychological Empowerment Scale (PES)...................................... 202
N. PES Permission............................................................................... 203
O. Conditions at Work Effectiveness Questionnaire (CWEQ- II).......... 204
P. CWEQ-II Permission....................................................................... 208
Q. AACN Recruitment Letter.............................................................. 209
R. AACN Permission........................................................................................................ 210
S. Room Permission ........................................................................................................ 211
T. IRB Approval .............................................................................................................. 212
U. Post-Intervention Interview-Feasibility Questions................................................. 213
V. Post-Intervention Interview- Empowerment Questions........................................ 214
W. Coding of Moral Distress Story Nurse A ................................................................. 215
X. Coding of Moral Distress Story Nurses K ................................................................. 217
Y. Coding of Moral Distress Story Nurse F ................................................................. 218
Z. Coding of Moral Distress Story Nurse B ................................................................. 220
AA. Coding of Moral Distress Story Nurse C .............................................................. 221
BB. Coding of Moral Distress Story Nurse D .............................................................. 222
CC. Coding of Moral Distress Story Nurse E .............................................................. 223
DD. Coding of Moral Distress Story Nurse G .............................................................. 225
EE. Coding of Moral Distress Story Nurse H .............................................................. 227
FF. Coding of Moral Distress Story Nurse I .............................................................. 229
GG. Coding of Moral Distress Story Nurse J .............................................................. 231
HH. Coding of Moral Distress Story Nurse L .............................................................. 233
II. Coding of Moral Distress Story Nurse M .............................................................. 235
JJ. Structural Code Analysis Coding of Moral Distress Stories ............................... 236
KK. Group 2 Intervention Data .................................................................................... 237
LL. Group 3 Intervention Data .................................................................................... 244
REFERENCES ............................................................................................................... 251
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Post Intervention Interview, Feasibility and Acceptability</td>
<td>113</td>
</tr>
<tr>
<td>2. Moral Distress Stories Themes and Codes</td>
<td>119</td>
</tr>
<tr>
<td>3. Weighing Options Group 1</td>
<td>128</td>
</tr>
<tr>
<td>4. Journal Club, Matheson and Bobay article</td>
<td>130</td>
</tr>
<tr>
<td>5. Journal Club, Fletcher article</td>
<td>134</td>
</tr>
<tr>
<td>6. Strategy Building and Planning, Group 1</td>
<td>136</td>
</tr>
<tr>
<td>7. Action Project, Group 1</td>
<td>138</td>
</tr>
<tr>
<td>8. Post Intervention Interview—Empowerment</td>
<td>140</td>
</tr>
<tr>
<td>9. Attendance Roster</td>
<td>152</td>
</tr>
<tr>
<td>10. Mean Pre and Post MDS-R, Frequency, Intensity, PES, CWEQ-II levels</td>
<td>153</td>
</tr>
<tr>
<td>11. MDS Q3= Frequency and Level</td>
<td>154</td>
</tr>
<tr>
<td>12. MDS Q4= Frequency and Level</td>
<td>155</td>
</tr>
<tr>
<td>13. MDS Q6= Frequency and Level</td>
<td>155</td>
</tr>
<tr>
<td>14. MDS Q7= Frequency and Level</td>
<td>156</td>
</tr>
<tr>
<td>15. MDS Q16= Frequency and Level</td>
<td>156</td>
</tr>
<tr>
<td>16. PES “Confidence in Ability to do Job”</td>
<td>158</td>
</tr>
<tr>
<td>17. PES “Work Important to Me”</td>
<td>158</td>
</tr>
<tr>
<td>18. PES “Autonomy to do the Job”</td>
<td>158</td>
</tr>
<tr>
<td>19. PES “Impact on what happens in the department is large”</td>
<td>159</td>
</tr>
<tr>
<td>20. PES “Great control of what happens in my department”</td>
<td>159</td>
</tr>
<tr>
<td>21. PES “Opportunity for independence and freedom”</td>
<td>159</td>
</tr>
</tbody>
</table>
22. Pre CWEQ-II “Info about current state of hospital” .......................... 160
23. Pre CWEQ-II “Access to info from top management” .......................... 161
24. Pre-CWEQ-II “Support helpful or problem-solving advice” ...................... 161
25. Pre CWEQ-II “Support comments to improve” ..................................... 161
26. Pre-CWEQ-II “Amount of visibility” .................................................. 162
27. Pre-CWEQ-II “Overall workplace empowering environment” ................... 162
28. Wilcoxon Ranked Between Pre and Post MDS-R Total .......................... 163
29. Wilcoxon Ranked Between Pre and post MDS-R Frequencies ................... 163
30. Wilcoxon Ranked Between Pre and Post MDS-R Intensity Levels ............... 163
31. Wilcoxon Ranked Between Pre and Post PES Levels ............................ 164
32. Wilcoxon Ranked Between Pre and Post PES Meaning Levels .................. 164
33. Wilcoxon Ranked Between Pre and Post CWEQ-II Levels ....................... 165
   KK  1. Weighing Options Group 2 ...................................................... 240
   KK  2. Strategy Building and Planning, Group 2 .................................... 242
   KK  3. Action Project, Group 2 ......................................................... 243
   LL  1. Weighing Options Group 3 ...................................................... 246
   LL  2. Strategy Building and Planning, Group 3 .................................... 287
   LL  3. Action Project, Group 3 ......................................................... 249
## LIST OF ILLUSTRATIONS

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Spiral Model</td>
<td>78</td>
</tr>
<tr>
<td>2. Syllabus for Session One</td>
<td>81</td>
</tr>
<tr>
<td>3. Syllabus for Session Two</td>
<td>83</td>
</tr>
<tr>
<td>4. Syllabus for Session Three</td>
<td>85</td>
</tr>
<tr>
<td>5. Understanding what already exists Group 1</td>
<td>127</td>
</tr>
<tr>
<td>6. Understanding where we wish to go Group 1</td>
<td>133</td>
</tr>
<tr>
<td>7. Schematic of movement through Freirean process</td>
<td>140</td>
</tr>
<tr>
<td>KK 1. Understanding what already exists Group 2</td>
<td>238</td>
</tr>
<tr>
<td>KK 2. Understanding where we wish to go Group 2</td>
<td>241</td>
</tr>
<tr>
<td>LL 1. Understanding what already exists Group 3</td>
<td>245</td>
</tr>
<tr>
<td>LL 2. Understanding where we wish to go Group 3</td>
<td>247</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

There are a number of people that I would like to acknowledge. First, I want to thank all of the nurses who participated in this study. I was truly touched by their love and dedication to their patients and the nursing profession. Second, I would like to thank Dr. Jennifer Hunter, who was my committee chair for the first four years and inspired me to think qualitatively and had a true passion for my research topic. Next, I would like to thank Dr. Amanda Emerson, who graciously took over as the chair of my committee in 2017 and worked tirelessly with me to organize and complete my lengthy dissertation. She also helped me become a much better writer.

In addition, I would like to thank Dr. John Lockhart from the Freirean Institute in the United Kingdom for coming to the University of Kansas City and guiding me through learning the Freirean process. I would not have been able to truly understand the Freirean process without him. Dr. Elizabeth Epstein from the University of Virginia shared her extensive expertise and knowledge about moral distress and provided invaluable insight to me along the way. Finally, I would like to thank Dr. John Llantos for providing perspectives from an ethical standpoint, and Dr. An-Lin Cheng for providing quantitative statistical method support.

On a personal note, I want to thank my husband Christopher, for his continued support during this long process, and a thank you to my beautiful Gracie who was by my side every step of the way and has enriched my life in so many ways. In addition, I would also like to thank my many friends, co-workers and neighbors who were always impressed that I was pursuing this degree at a later stage in my life, and always gave me an encouraging word.
CHAPTER 1
INTRODUCTION

A moral agent is a person who makes moral judgments based on their understanding of right and wrong (Parthemore & Whitby, 2014). Nurses act as moral agents for patients and use their moral sensitivity to build trusting relationships with an ethical motivation to act in their patients’ best interests (Storch, Rodney, Pauly & Starzomski, 2002). When a moral agent becomes seriously compromised and acts against their personal and professional values, they may experience what is known as moral distress. In 1984, Andrew Jameton defined moral distress as the negative state of mind that arises when one knows the morally correct response to a situation but cannot act as a moral agent because of institutional or hierarchical constraints.

Nurses in the United States (Corley, Elswick, Gorman & Clor, 2001; Hamric, Borchers, & Epstein, 2012) and globally (Oh & Gastmans, 2015; Piers et al., 2014) are highly susceptible to moral distress. The American Association of Critical Care Nurses (AACN, 2004), the American Nurses Association (ANA, 2015) and the Canadian Nurses Association (CNA, 2017) have all established position statements on moral distress. While this dissertation is focused on moral distress in nursing, other health care professionals, including physicians, report suffering from moral distress as well (Allen et al., 2013; Houston et al., 2013; Whitehead, Herbertson, Hamric, Epstein & Fisher, 2015).

There is strong evidence that futile care, negative ethical climate, and unequal power hierarchies prevalent in institutions greatly contribute to the experience of moral distress in nursing (Dodek et al. 2016; Oh & Gastmans, 2015; Huffman & Rittenmeyer, 2012; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012a). Nurses who have suffered from moral distress
describe hierarchical constraint as a lack of autonomy and power in decisions that concern
patient care (Austin, Lemermeyer, Goldberg, Burgum & Johnson, 2005; Dodek et al., 2016;
Elpern, Covert & Kleinpell, 2005; Epstein & Delgado, 2010). The experience of
powerlessness, of being stuck and pressured to do what one believes to be wrong, is a key
theme in descriptions of moral distress (Carse, 2013).

Moral residue, the emotional residue that remains with a person after an instance of
moral distress causes a number of physical, psychological, and stress-related responses that
are consistent with the inability to function as a moral agent (Epstein & Delgado, 2010;
Webster & Bayliss, 2000). The responses that arise from moral residue become part of
nurses’ lived experience and are therefore integrated into their work life and interpersonal
relationships (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015. Although studied
predominantly in critical care, moral distress has also been identified and studied in nurses
from diverse work environments, such as oncology, medical-surgical, surgery, geriatric care,
extended care, operating room, and primary care (Huffman & Rittenmeyer, 2012; Oh &
Gastmans, 2015).

Behavioral responses to moral residue documented in the literature include
emotional exhaustion (Meltzer & Huckabay, 2004); headache (Wilkinson, 1987); tearfulness
and anger, 1984); sarcasm, guilt, and withdrawal (Ferrell, 2006); and depersonalization
(Ohnishi et al., 2010). Nurses report feeling compelled to withdraw from patient care (Fry,
Harvey, Hurley & Foley, 2002) and have dissatisfaction and burnout, often leaving nursing
as a result (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). Research in the United
States and around the world has shown factors such as futile care, negative ethical climate,
and unequal power hierarchies to be responsible for moral distress in nursing (Shorideh,
Ashtorab & Yaghmaei, 2012; de Veer et al., 2013; Ganz et al., 2012). Stress-related responses to moral distress elsewhere in the world are similar to that in the United States and include withdrawing from patient care, dissatisfaction, burnout, and leaving the nursing profession (Shorideh et al., 2012; de Veer, Francke, Struijs and Willems, 2013; Ganz et al., 2012).

While strong evidence has linked powerlessness and uneven power dynamics to the development of moral distress in nurses (Austin et al., 2005; Oh & Gastmans, 2010; Huffman & Rittenmeyer, 2012), the reasons why this powerlessness occurs and the ways in which uneven power dynamics affect the moral distress nurses experience are topics that have not been researched thoroughly. Further, nurses who have experienced moral distress emphasize that, due to organizational constraints, trying to effect change is a significant struggle (Peter, Lunardi & McFarland, 2004; Pauly, Varcoe, Webster & Storch, 2012b). One meta-analysis revealed that nurses who attempted to stand up for themselves in morally challenging patient care situations were met with retribution or loss of employment (Peter, et al., 2004). Moreover, despite research identifying the lack of perceived empowerment as a cause of moral distress, only a few interventional studies have been designed to increase nurse well-being or feelings of self-efficacy or empowerment in the framework of moral distress (Beumer, 2008; Leggett, Wasson, Sinacore & Gamelli, 2013; Pavlish, Hellyer, Brown-Saltzman, Miers & Squire, 2013).

Nursing is embedded in a history of sequenced oppression (Cudd, 2006). As defined by Cudd (2006) sequenced oppression begins when one group dominates over another group, and then the dynamics are set into motion that perpetuate that oppression. In nursing, the history of sequenced oppression can be discerned in nursing’s origin as a religious calling.
(Carson, 1989; Tyler & Raynor, 2006), its relationship with medicine (Fletcher, 2006), the impact of that relationship on early twentieth century nursing education and hospital work (Nelson, 2001), and the gendered dimension of nursing as female work (Farrell, 2001; Manojlovich, 2007; Rafferty, 2014).

Because of nursing’s relative lack of power in the health care hierarchy, nurses have been described by researchers and theorists as an oppressed group (Roberts, 1983; Young, 1990). Behaviors such as lateral violence (Roberts, 1983), passive-aggression and silencing (DeMarco, 2002), and marginalization (Croft & Cash, 2012) that have been displayed in nursing are similar to behaviors found in other oppressed groups. Like other oppressed groups, nurses often lack insight into their oppression and struggle to overcome it on their own (Roberts, 1983; DeMarco, 2002). Because of the similarities in experiences across oppressed groups, one way to address moral distress in nursing may lie in applying interventions for moral distress that have been developed and used in other realms to help groups recognize and overcome powerlessness (Ridner, 2004).

Paulo Freire’s *Pedagogy of the Oppressed* offers a theoretical framework designed to help people recognize and overcome powerlessness and oppression. Assumptions from Freire’s philosophy that are tested in this dissertation are that Freire’s (1995) problem-posing education, adapted for nurses who have experienced moral distress, can provide a vehicle for critical reflection and dialogue, and, in turn, support a reconsideration of choices and enhanced opportunities for healing. Because the process of conscientization enables empowerment in a group process of critical reflection and dialogue (Freire, 1995), the hypothesis for this project was that, combined with skillful question posing, group identification of personal experiences of oppression through conscientization would (1)
illuminated for participating nurses how their moral distress was a consequence of group oppression and lack of empowerment, and (2) produce social connectedness and mutual motivation for change among nurses.

For the present study, a conscientization problem-posing intervention for nurses who suffer from moral distress was developed and piloted. The pilot study demonstrated that the conscientization intervention is feasible and acceptable to participants. Narrative analysis of the moral distress stories of participating nurses revealed themes of powerlessness in nurse relationships with families, organizations, and physicians. Evaluation of goal attainment from each session revealed that nurses experienced increased perceived empowerment during movement through the sessions (a) critical reflection, (b) critical motivation, and (c) critical action. Interviews indicated that nurses gained an increased understanding of moral distress and a sense of overall personal empowerment after the intervention. Survey results showed a significant post-intervention decrease in moral distress mean levels and moral distress frequency, a significant increase in moral distress intensity, but no significant change in mean levels of psychological or structural empowerment. The pilot study demonstrated that a conscientization intervention formulated around critical reflection, critical motivation, and critical action and delivered in a small-group format with nurses is a feasible and acceptable way to reduce moral distress levels and enhance personal and group empowerment. Reducing moral distress among nurses is crucial for reducing burnout and improving patient care.

**Study Purpose and Specific Aims**

The purpose of this study was to develop, and pilot test a conscientization intervention, based on Freirean pedagogy, that identifies oppressive factors related to moral
distress in nurses and promotes empowerment (Freire, 1995). The intervention was piloted for feasibility, acceptability, and initial outcomes with 13 critical care nurses in four critical care units from three hospitals in the Midwest U.S. Nurses were eligible if they reported having experienced moral distress in the previous year.

The specific aims were

1. To develop a Freirean-based conscientization intervention for critical care nurses who have recently experienced moral distress.
2. To evaluate feasibility and acceptability of the developed intervention.
3. To evaluate the impact of a conscientization intervention on moral distress levels and on individual nurses’ and the group’s sense of both psychological and structural empowerment.

**Definition of Terms**

The following definitions are provided to provide clarity on moral distress and associated ideas of Freirean pedagogy, problem-posing education, and conscientization.

**Agency**

Agency refers to the ability of a person to act intentionally (Bandura, 2001). The attributes of agency—intentional, forethinking, self-reactive, and self-reflective—enable people to play a part in their self-development and self-renewal (Bandura, 2001).

**Freirean**

Any concept or idea based on Paulo Freire’s theory of how oppression operates and how it can be challenged through collective problem-posing, reflection, and critical action.

**Pedagogy of the Oppressed**

The title of a book by Paulo Freire that expounds a type of teaching built on and
aiming for a new relationship between teacher, student, and society. This approach helps the oppressed reflect on the causes of their oppression, facilitates self-discovery, and promotes engagement in action to free themselves. Freire’s educational approach aims to provide empowerment for the student and a more democratic process of education (Freire, 1995; Giroux, 2010).

**Problem-Posing Education**

The educational approach proposed by Paulo Freire (1995) that helps oppressed people challenge their own perception of the dominant group (oppressor) (Rugut & Osman, 2013). Since the oppressed think of themselves as “less than” the dominant group, this educational program includes engaging the learner in a process of disidentification with the dominant culture (oppressor) to help them imagine a new reality, and take action towards that new reality (Freire, 1995). It is a group process that relies on individuals’ sharing personal experiences to produce a group connection and a shared concern for change within that group (Freire, 1995; Wallerstein & Auerbach, 2004).

**Praxis (Action/Reflection)**

People gaining knowledge of their social reality and acting together to change their social reality, followed by critical reflection on that action (Freire Institute, 2016).

**Animateur**

The person leading the problem-posing intervention; this role is an active one that is meant to challenge, provoke, and stimulate a learning session (Wallerstein & Auerbach, 2004). It is the job of the animateur to help the learners achieve a form of critical thinking about the situation (Rugut & Osman, 2013).

**Generative Themes**
In a problem-posing intervention, generative themes are cultural or political topics of importance to the group (Rugut & Osman, 2013), and are elicited in the process of striving toward self-awareness (Freire Institute, 2016). For the purposes of this study, the generative theme is moral distress.

**Codification**

A representation of the generative themes through such things as pictures, music, stories, among other things (Freire, 2016). Codification is a way of gathering information in order to build (codify) up a picture around these generative themes about situations and real people. Participants are able to step back from these codifications of their themes and decode or explore them critically by regarding them objectively (Rugut & Osman, 2013). For the purposes of this study, codification happens when the nurses compose and read their moral distress stories.

**Decodification**

This is the process whereby the people in a group begin to identify with aspects of the situation until they feel themselves to be in the situation and able to reflect critically upon its various aspects, thus gathering understanding (Rugut & Osman, 2013). For the purposes of this study, decodification is the groups’ work on breaking down the moral distress stories in order to see the role that power and oppression had on the situations.

**Conscientization (Conscientização; Portuguese)**

A dynamic process of humans becoming more aware of the sources of their oppression. This process produces knowledge and includes critical self-reflection (praxis) and reflection about the structures that perpetuate current power relations in a society. Increased reflection and awareness prompts action in the form of developing skills and
utilizing resources to change oppressive components (Freire, 1995).

Assumptions and Hypotheses

The assumptions and the hypotheses that they informed in this study were guided by the Freirean theoretical framework and the literature on moral distress in nurses.

Assumptions

1. Nurses are members of a historically oppressed group.
2. Nurses’ oppression arises from their lack power within the health care hierarchy.
3. Moral distress in nursing is a result of nurses’ lack of power within the health care hierarchy.

Hypotheses

Based on the assumptions adapted from the Freirean framework of pedagogy of the oppressed, I formed the following hypotheses:

1. Application of a conscientization intervention will be feasible and acceptable.
2. Application of a conscientization intervention with a group of nurses who reported having experienced moral distress will illuminate key components of moral distress and its connections to oppression.
3. Application of a conscientization intervention with a group of nurses who reported having experienced moral distress will be associated with lower levels of moral distress, increased reported feelings of personal empowerment, and increased PES and CWEQ-II levels.
CHAPTER 2
REVIEW OF LITERATURE

Introduction

In this chapter, in the first main section, I give an overview of the research related to moral distress in nursing, beginning with the ethical origins of moral distress and ending with the operationalization of the concept. In the second main section, I review the literature that connects moral distress in nursing to theories of power and oppression. I end the chapter with an overview of the theoretical framework of Paulo Freire as presented in his watershed work Pedagogy of the Oppressed, including a description of the components of Freire’s problem-posing education.

Ethical Origins of Moral Distress in Nursing

The literature on moral distress in nursing identifies its conceptual origins in ethics. Parthemore and Whitby (2013) defined moral agency as an individual's ability to make moral judgments based on some notion of right and wrong. They go on to characterize a moral agent as a person who is capable of acting with reference to right and wrong and who is accountable for those actions (Parthemore & Whitby, 2013). Storch et al., (2002) believed that nurses are inspired by ethical motivations or considerations of rightness or probity to act in their patients’ best interests.

There are a number of studies that have developed the ethical components of moral agency, concepts that are central to the idea of moral distress. In a study that sought to examine nurses’ and physicians’ moral sensitivity in the ethical dimensions of clinical practice, Lützén, Johansson and Nordström (2000) found that nurses developed moral sensitivity or “the ability to recognize a moral conflict, show a contextual and intuitive
understanding of the patient’s vulnerable situation, and have insight into the ethical consequences of decision on behalf of the person” (p. 521). Storch et al., (2002) believed that nurses use moral sensitivity to build trusting relationships with an ethical motivation to act in their patients’ best interest.

While Lützén’s (2000) and colleagues’ notion of moral sensitivity highlighted a person’s awareness of moral conflict, others have focused on how a person’s response to such conflict has implications for the moral agent’s sense of self and the self’s ability to act. de Raeve (1998) for example, defined *moral integrity* as an adherence to moral values that affects the individual’s sense of dignity and self-respect. Rest (1986) described *moral competency* as the ability to engage in morally appropriate behavior by making moral sense of situations, using good moral judgment and intention, and engaging in morally appropriate behavior. Lindh, Severinsson, and Berg (2007) explained *moral responsibility* as “a relational way of being, which involved guidance by one’s inner compass composed of ideals, values and knowledge that translate into a striving to do good” (p. 129). Nursing theorists such as Wilkinson (1987) and Corley et al. (2001) have also shown great interest in understanding the ethical grounds for moral distress by focusing on the notion that nursing is a moral endeavor and arguing that morality and ethics are central to nursing practice.

**History and Conceptualization of Moral Distress**

The interpretation of moral distress in nursing has evolved over the last 34 years, since it was first described in 1984 by Andrew Jameton. In the following section, influential scholars on moral distress will be discussed, starting with Jameton (1984) and ending with Colleen Varcoe (2012). Since moral distress is a concept that has developed over time, it is important to understand how earlier work shaped the understanding of moral distress.
research as it stands in nursing research today.

**Jameton to Campbell: Conceptualization to Operationalization**

In 1984, American philosopher and bioethicist Andrew Jameton authored *Nursing Practice: The Ethical Issue* in which he introduced the phenomenon of moral distress. Jameton’s book was based on the ethnographic research on nurses and their everyday practice that he conducted in the late 1970s. Building on Marlene Kramer’s 1974 book *Reality Shock*, Jameton speculated that burnout in nursing was partly due to conflicts nurses experienced with moral and ethical issues.

In his research, Jameton noticed that nurses became distressed when they were expected to carry out orders on patients that they felt were unnecessary. For example, Jameton revealed that nurses registered distress when patients were getting unnecessary blood tests because they felt that the additional blood draws were unethical. The distress arose from feeling that not only did they have no authority over the decision to order additional blood tests but the feeling that they also had no grounds for expressing their qualms, no foundation for even raising questions. Some felt that doing so would pose risks to keeping their job. This was an ethical issue for the nurses. Importantly, however, the distress was not caused by not knowing what ethical action to take but by not being able to carry out the ethical action they would have chosen (Jameton, 1984).

Jameton defined moral distress as “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Until this concept of moral distress was introduced, distress among clinicians had been recognized mostly through concepts such as stress and burnout (Rodney, 2017). Although stress and burnout are often the effects of moral distress, those outcomes do not communicate the
ethical basis of the stress that the nurses were suffering. With the introduction of moral
distress, Jameton added an ethical component to the study of distress. Nurse scholars
became interested in this new distress concept, and began to explore it (Rodney, 2017).

In 1987, nurse researcher Judith Wilkinson sought to expand on Jameton’s ethics
research in nursing by asking how the moral aspects of nursing affected the quality of
patient care. Wilkinson interviewed 24 nurses randomly sampled from pools of state boards
of nursing. Her data revealed that there were a number of indicators associated with moral
distress. These indicators were related to the types of cases (prolonging life, unnecessary
tests and treatments), frequency of events (how often it occurs), context (orders from
physicians or administration), psychological feelings (anger, anxiety, frustration,
powerlessness), lack of sense of wholeness (loss of self-worth, effect on personal
relationships), effect of moral distress on patient care (better, worse, or not affected), and
behavioral responses (avoidance of patients, leaving job).

Wilkinson (1987) recognized that feelings of frustration, anger, guilt, anxiety and
powerlessness were a reaction to moral distress and posited that they occurred because
nurses did not feel whole in their moral agency to provide patient care. She defined moral
distress as the “psychological disequilibrium and negative feeling state experienced when a
person makes a moral decision but does not follow through by performing the moral
behavior indicated by that decision” (p. 16). When she noted that 11 out of the 24 nurses
(46%) that were interviewed left nursing as a result of their morally distressing situation, it
raised the question concerning moral distress and nursing retention (Wilkinson, 1987).

In 1993, Jameton revised his original definition of moral distress by underscoring
that moral responsibility was the main ethical challenge when moral distress happens. In this
updated version, Jameton (1993) divided the moral distress experience into two dimensions: *initial distress* and *reactive distress*. Initial distress is the initial reaction of anger, frustration, or exasperation that the nurse experiences when they are unable to follow through on what they believe to be their moral responsibility. Reactive distress is the response of the nurse to their continuing inability to react in a morally responsible way, often evolving into a sense of powerlessness (Jameton, 1993).

Building on concepts from Jameton (1984, 1993) and results from Wilkinson’s (1987) study, nurse researcher Mary Corley (1995) developed the first quantitative tool to measure moral distress, the Moral Distress Scale (MDS). Testing of the 38-question 7-item Likert scale was performed with a convenience sample of 111 critical care nurses from a local chapter of American Association of Critical Care (AACN) (Corley, 1995). Even though the overall mean scores on moral distress levels were low in that sample, the response ranges revealed that some nurses did experience high levels of moral distress. Situations associated with the ethical issues that led to moral distress included prolonging life, performing unnecessary tests, and truth-telling—similar to the issues identified by Wilkinson (Corley, 1995; Wilkinson, 1987). Also similar to Wilkinson’s results, 12% of the nurses indicated that they left a nursing position as a result of moral distress, further confirming the connection between moral distress and retention in nursing (Corley, 1995).

Corley and colleagues did additional tool development on the MDS in 2001 and decreased the items on the tool to 32 (Corley et al., 2001). In developing the tool, the MDS was distributed to 214 nurses from several hospitals across the United States. The overall mean moral distress level was in the moderate-high range, with the highest scoring item *working with low levels of staff*. Factor analysis revealed three sources of moral distress. The
first factor, *individual responsibility*, reflected role conflict or a situation in which a person is expected to play two incompatible roles (Katz, 1978). According to Corley et al. (2001) moral distress arises around individual responsibility because nurses have more responsibilities than rights, and the institutional constraints consistently direct nurses’ behaviors while not always reflecting their values. The second factor was *not in patient’s best interest*, meaning that the nurse has to act in ways that they believed would not benefit the patient. The third factor was *deception*, meaning that nurses are not acting in accordance with their values; they feel morally responsible, yet their role in the organization constrains them (Corley et al., 2001).

The cluster of three items on *deception* were (a) partial code, (b) MD request not to discuss code with patient, and (c) IV medication given if patient refuses oral medication. The top three clusters on *individual responsibility* were: (a) perform procedures without consent, (b) medical student practicing on patients, and (c) physician practicing on patients (Corley et al., 2001). These factors suggest that *deception* involves holding the truth from patients resulting in reduced patient autonomy, whereas with *individual responsibility*, there is role conflict in that others in organization are performing actions that cause conflict (Corley et al., 2001). As Corley et al. (2001) suggests, and as is explained through Boyle’s (1997) work, the cluster of items on deception points to the core of a major ethical principle: the importance of truth-telling as a means of respecting patient autonomy (Boyle, 1997).

In 2002 Corley introduced *moral distress theory* based on the premise that nurses are moral agents and nursing is a moral profession. Moral distress theory contains seven interrelated moral concepts, including commitment, sensitivity, autonomy, sense-making, judgment, conflict competency, and certainty (Corley, 2002). This explanatory theory
postulates a complex network of relationships among the seven moral concepts along with situations that account for the development of moral distress. Globally, the theory explains that moral distress arises from two perspectives: individual and organizational. The individual perspective is molded out of the belief framework of the individual nurse and how that impacts the seven interrelated moral concepts. The organizational perspective is affected by such things as ethical work climate, collegial relationships with staff and physicians, and the nurse’s overall perception of their ability to influence their work (Corley, 2002).

As mentioned previously, moral residue is the emotional excess that remains with a person after an instance of moral distress (Webster & Bayliss, 2000). Moral residue is more likely to happen when morally distressing episodes recur over time (Epstein & Delgado, 2010; Webster & Bayliss, 2000). In 2009, Epstein and Hamric proposed a model to describe the relationship between moral distress and moral residue. The model is called the crescendo effect because a crescendo builds when morally distressing situations occur and resolve repeatedly. The model as reported in Epstein and Hamric (2009) is based on Epstein’s (2007) synthesis of findings, interviews with end-of life experiences of parents (n = 21), nurses (n = 21), and physicians (n = 11), and interviews taking place shortly after an infant death in a newborn intensive care unit.

As reported in Epstein and Hamric (2009) nurses in the Epstein (2007) study experienced a growing perception of moral distress that turned into moral residue after the nurses were exposed repeatedly to the experience of taking care of a critically ill infant. The crescendo model holds that nurses who have not yet experienced a morally distressing situation start at baseline with no moral residue. Once they have one exposure, moral residue
results, and with repeated exposures, the level of moral residue gradually rises. As the residue rises, caregivers react more intensely to situations, especially those situations that are similar to ones that caused problems in the past (Epstein & Hamric, 2009). It is the repetitive nature of distressing clinical situations that adds a sense of futility, thus increasing the moral residue. This aspect of moral distress, the residue that remains when morally distressing episodes repeat over time, can be damaging to oneself and one’s career (Epstein & Delgado, 2010).

A more recent interpretation of moral distress emphasizes that moral distress is a layered, complex, interactive experience that is shaped by multiple contexts, including the socio-political and cultural contexts of the workplace environment (Varcoe et al., 2012a). Varcoe and colleagues based their new interpretation of moral distress in nursing on results from their open-ended survey of 292 nurses from various acute care areas in British Columbia, Canada (2012). Three open-ended questions asked respondents to describe a situation where they experienced moral distress, the action taken by the nurse (if any) during the morally distressing situation, and the effect that the moral distress had on the care of the patient (Varcoe et al., 2012a).

Varcoe et al.’s (2012a) study showed that situations that caused moral distress were both patient and system-related. Prolongation of suffering of the patient was frequently cited as clinically relevant, and system issues such as low staffing and lack of leadership played a part as well (Varcoe et al., 2012a). The depictions of the types of action taken by the nurses were striking for the remarkable amount of effort and energy reportedly spent by nurses as they tried to effect change or rectify the morally distressing situation. Called Action in the face of moral distress, the most disturbing aspect for nurses was the discrepancy between the
large amounts of energy expended on their part and the lack of results or resolution of the problem (Varcoe et al., 2012a, p. 495). Nurses described their belief that the morally distressing situations could have been resolved, but their pleas were dismissed by those who had the power to enact change (Varcoe et al., 2012a).

Varcoe et al. (2012b) argued that defining moral distress as just the inability to pursue the right course of action discounts the exceptional and continual actions by nurses who attempt to fix the situations. She proposed that perhaps nurses’ efforts are not successful due to perceived and actual powerlessness within hierarchical health care workplaces. Redefining moral distress as a relational concept, one that occurs as a result of a nurse’s complex ethical interactions in relation to patients and in relation to a system takes into account the settings of practice and the power dynamics that make up a situation in which moral distress arises (Varcoe et al., 2012b). A definition that acknowledges nurses’ actual and perceived powerlessness within hierarchical health care workplaces provides for a fuller understanding of the dynamics of moral agency and may lead to better support for the development of moral competency (Varcoe et al., 2012b).

In 2013, Peter and Liaschenko proposed using feminist ethics to add some theoretical complexity to the concept of moral distress. They used the work of feminists Margaret Urban Walker and Hilde Lindemann and argued that moral distress was the response to constraints experienced by nurses to their moral identities, responsibilities, and relationships (Peter & Liaschenko, 2013). They recommended that health professionals learn to account for and communicate their values and responsibilities, create “counterstories” to attest to nurses’ skill and trustworthiness to fix their broken moral identities, and the undertaking
toward the relief of human suffering as the goal of health care as opposed to the
prolongation of life at all costs (Peter & Liaschenko, 2013).

Campbell, Ulrich and Grady (2016) introduced a broad expansion for the definition
of moral distress presenting six types of distress that fall outside the bounds of the traditional
definition. These six types are (a) moral uncertainty, (b) mild distress, (c) delayed distress,
(d) moral dilemma, (e) bad moral luck, (f) and distress by association. Campbell et al.’s
(2016) proposed moral distress definition is “one or more negative self-directed emotions
or attitudes that arise in response to one’s perceived involvement in a situation that one
perceives to be morally undesirable” (p 6).

For this research study, I adopted Varcoe et al.’s (2012b) interpretation of moral
distress. Moral distress occurs as a result of a nurse’s complex ethical interactions in relation
to patients in the context of structural power dynamics over which the nurse often has or
perceives themself to have little control. This account of moral distress pointedly
acknowledges both actual and perceived powerlessness within the hierarchical workplace as
a cause of moral distress. The intervention for this dissertation was developed with the aim
of empowering nurses who have experienced moral distress in order to reduce nurse burnout,
improve nurse job satisfaction and retention, and improve patient outcomes.

Moral Distress in Nursing

In the following section, the scope, sources, behavioral responses to moral distress,
and consequences of moral distress in nursing will be discussed. This discussion will be
followed by a brief overview of studies that include nursing and other multidisciplinary
health care providers. Even though the vast majority of research on moral distress has been
done in nursing and the focus of this dissertation is moral distress in nursing, it is important to note how the phenomenon has affected other health care team members.

**Scope of Moral Distress**

Since Jameton (1984) introduced moral distress, we have learned that nurses in the United States (Corley, 1995; Corley et al., 2001; Hamric et al., 2012) and globally (Dodek et al., 2016; Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015; Piers, et al., 2014) are highly susceptible to moral distress. Between 26% and 50% of nurses have reported leaving or changing practice sites due to moral distress (Corley, 2002; Hamric et al., 2012; Wilkinson, 1987). Moral distress is such a prevalent problem in nursing that three professional nursing organizations issued statements or reports to address it specifically (AACN, 2004; ANA, 2010; CNA, 2017). The American Association of Critical Care Nurses (AACN) established a framework called *The 4 A’s to Rise Above Moral Distress* to assist nurses in dealing with moral distress (Rushton, 2006). The ANA *Code of ethics* (2010) and revised position statement (ANA, 2015) sets forth the need for group support in facing ethically and morally challenging struggles. The *Code of ethics* for Canadian nurses addresses moral distress by name and gives guidance for recognizing moral distress in team members (CNA, 2017).

**Sources of Moral Distress**

Research on moral distress indicates that there are three general sources of distress: specific clinical situations, factors internal to the individuals and professional factors present in unit culture and norms of institutions and the health care environment at large. These sources were documented in Oh and Gastmans’ (2015) review of quantitative studies and Huffman and Rittenmeyer’s (2012) review of qualitative studies. Piers et al. (2014) along
with Varcoe et al. (2012a) and others reported that participating in futile patient care is the leading clinical scenario resulting in moral distress. Wilson, Goettemoeller, Bevan, and McCord (2013) and McAndrew, Leske, and Garcia (2011) described that working with physicians they considered unsafe and lack of trust in team members are rated as often causing moral distress.

Pauly, Varcoe, Storch and Newton (2009) along with Ganz et al. (2012) and others reported on the prominent role that poor ethical climate and perceived lack of power in the workplace play in causing moral distress. While a number of researchers have reported on data from qualitative studies to uncover causes of moral distress, initially many relied on the MDS to detect and quantify moral distress. Now most researchers rely on the updated tool developed by Hamric et al., (2012) called the Moral Distress Scale-Revised (MDS-R). This newer scale which will be discussed in detail ahead in this paper.

The MDS reports sources for moral distress though six dimensions that are grouped in three categories correspondent to circumstances, deception, and internal and professional standards of practice: Futile care, euthanasia, deception, physician practice, nursing practice, and institutional/work climate (Corley et al., 2001). The six dimensions are divided into three groups and are discussed below.

**Group One: Futile Care/Euthanasia Circumstances related to Specific Clinical Situations**

Based on literature reviews of both quantitative (Oh & Gastmans, 2015) and qualitative (Huffman & Rittenmeyer, 2012) studies, there is strong evidence that the perception of futile care greatly contributes to moral distress in nursing across all cultural contexts and in various critical care unit types (Cavaliere, Daly, Dowling & Montgomery,
Researchers have similarly found futile care to be a frequent source of moral distress in the pediatric nursing population (Cavaliere, et al., 2010) and in the medical-surgical nurse population (Rice et al., 2008).

Researchers have also sought to understand how nurses and physicians think similarly or differently about moral distress, ethical climate, and futile care. Hamric and Blackhall (2007), for example, evaluated the relationship between moral distress and ethical climate in nurses and physicians in the United States, while Piers et al. (2014) attempted to determine differences between nurses and physicians in perceptions of futile care. Using the MDS and Olson’s Hospital Ethical Climate Survey (HECS) to measure ethical climate, Hamric and Blackhall (2007) found that the highest moral distress situations for both registered nurses and physicians involved those situations in which caregivers felt pressured to continue unwarranted aggressive treatment. Piers et al. (2012) found that futile and inadequate care contributed to moral distress in both nurses and physicians.

Researchers using qualitative approaches and surveys other than the MDS have reported the perception of futile care as a factor associated with moral distress (Atabay, Cangarli, & Penbek, 2014; Shorideh et al., 2012). Futile care as a source of moral distress was also uncovered by Weigand and Funk (2012) who sought to identify clinical situations that caused nurses to experience moral distress using open-ended surveys. In that study, involving 204 critical care nurses, futile care administered at end of life accounted for 79% of reported moral distress (Weigand & Funk (2012). Finally, Pavlish, Brown-Saltzman, Hersh, Shirk, and Nudelman (2011) employed a critical incident report technique to determine factors that affected ethical issues in nursing practice. In critical incident reporting, participants are asked to provide descriptions of real-life ethically challenging patient care.
events, including early signs of problems, nursing actions, outcomes from the event, and a rating for the general risk level. Ninety percent of the incidents reported in the Pavlish et al. (2011) study were related to futile care at end of life. Moral distress is experienced when helping patients in palliative care as well. In a recent study, Young, Froggat, and Brearley (2017) found that nurses in palliative care in the United Kingdom who experienced moral distress when they felt powerless to help patients achieve a good death. Even when the intent of patient care is not to prolong life, moral distress can occur when nurses feel that they failed to provide the patient with a peaceful death (Young et al., 2017).

In summary, researchers in numerous studies have found that the perception of futile care greatly contributes to moral distress in nursing. The most frequently reported clinical situation to cause moral distress is futile care and aggressive care, especially at end-of-life (Mobley et al., 2007; Varcoe et al., 2012a; Wilson et al., 2013). The comparative influence of this category of care on moral distress was high in both quantitative and qualitative studies, across various types of clinical settings including adult and pediatrics, and in the United States and globally (Atabay et al., 2014; Shorideh, et al., 2012).

**Group Two: Deception/Physician Practice/Nursing Practice Dimension Factors internal to the Individual and Professional**

The literature on moral distress has also shown that unsafe staff, unethical conduct, and lack of trust and collegiality among health care workers contributes to moral distress. Corley, Minick and Elswick (2005) examined the relationship between moral distress and the ethical work environment in 106 nurses from two large medical centers. Using the MDS to evaluate sources, the dimension of *working with unsafe staff* was scored highest by the staff on the scale. Likewise, Zuzelo (2007) evaluated moral distress in 100 critical care
nurses in one an urban medical center in the United States. Using the MDS and open-ended questions, the top morally distressing event included working at staffing levels (staff: patient ratios) perceived as unsafe (Zuzelo, 2007).

Other studies have found results related to lack of collegiality among health care workers and unethical conduct. McAndrew et al. (2011) found that poor physician/nurse collegial relationships greatly impacted moral distress, with the intensity of moral distress inversely related to physician/nurse collegial relationship ($r = -.25, p = .003$). Rice et al. (2008) found high levels of moral distress related to professional practice environment and lack of communication dimensions and Wilson et al. (2013) found lack of competency of staff (nurses and physicians) as the key issues associated with moral distress. Other studies have found significant relationships between moral distress and ethical climate in nurses and physicians, including lower satisfaction scores, lower ethical climate/environment, and lower collaboration scores in RNs with higher versus those with lower moral distress (Hamric & Blackhall, 2007).

Internationally, researchers have found similar connections between perceptions of ethical climate and moral distress. Silén, Svantesson, Kjellstrom. Sidenvall, and Christensson (2011) discovered that high levels of moral distress correlated with lack of safe and appropriate care by staff, which included lying to patients. Similar results were found in studies measuring moral distress among psychiatric nurses from Jordan (Hamaideh, 2014) and from Japan (Oshnishi et al., 2010), which found moral distress to be associated with inappropriate care by staff and burnout, respectively.

To review, it is well-established that working with unsafe staff, unethical conduct of staff, and unhealthy collegial relationships between nurses and physicians have negative
impacts on levels of moral distress among nurses (Zuzelo 2007; McAndrew et al., 2011; Rice et al., 2008). This is evident across different types of clinical settings including psychiatric nursing, in the United States and globally as well (Hamaideh 2014; Ohnishi et al., 2010; Silén et al., 2011).

**Group Three: Institutional/Work Climate Factors present in Unit Culture/ Institutions and Health Care Environment at Large**

Based on literature reviews of both quantitative (Oh & Gastmans, 2015) and qualitative (Huffman & Rittenmeyer, 2012) studies, there is strong evidence that negative ethical climate contributes to moral distress in nursing in all cultural contexts. Ethical climate in these studies refers to ethical conflicts, ethical problems, and ethical dilemmas (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). Additionally, both unit and site-specific administrative and general organizational structures have been shown to impede nurses’ ability to be moral agents for patients (Oh & Gastmans, 2015).

A number of studies have shown that negative correlations exist between moral distress scores and ethical climate, meaning the lower the ethical environment score, the higher the moral distress score. Pauly et al. (2009) from Canada and Hamric and Blackhall (2007) from the United States both conducted studies that evaluated the relationship between moral distress and ethical climate. Both used the MDS to measure moral distress and Olson’s Hospital Ethical Climate Survey (HECS) to measure ethical climate, and both documented negative correlations between moral distress scores and ethical climate. Similar studies were reported in Corley et al. (2005) and Silén et al. (2011). In Turkey, Atabay et al. (2014) investigated the relationship between various types of ethical climates and moral distress intensity in nurses. Two hundred-one nurses completed the MDS and Olson’s
Hospital Ethical Climate Survey. The ethical data from Olson’s Hospital Ethical Climate Survey was then applied to a framework developed by Victor and Cullen (1988) that measures ethical climates in organizations. The framework by Victor and Cullen (1988) contains a grid in which data from the ethical climate are indexed according to three factors in ethics: egoism (the view that morality ultimately rests on self-interest), benevolence (disposition to do good), and principle (a comprehensive and fundamental law, doctrine, or assumption). In this study, four ethical climate types were found: rules, well-being of stakeholders, individualism, and organizational interests. Out of these four ethical climates, individualism, \( r = .443, p < .001 \), and organizational interests, \( r = .443, p < .001 \), were correlated with a higher level of moral distress intensity, while no type of ethical climate was found to reduce moral distress intensity (Atabay et al., 2014).

Unit and site-specific administrative structures and general organizational structures have been found to impede nurses’ ability to be moral agents for patients (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). Studies from Canada (Austin, Bergum, & Goldberg, 2003) and Norway (Torjuul & Sorlie, 2006) revealed the impact that administrative factors can have on nurses’ ability to be moral agents. Both studies used a hermeneutic phenomenological approach to describe factors within organizations that were interfering with nurses’ providing ethical care to patients. In Canada (Austin et al., 2003), thematic analysis of nurses’ stories revealed that a lack of administrative support, a lack of administrative respect, and a lack of being listened to from administration left nurses feeling dispirited. In Norway, thematic analysis of ten narratives related to ethically difficult patient care situations revealed that heavy workload, lack of time, and staffing problems resulted in difficult ethical prioritizations and reduced standards of care (Torjuul & Sorlie, 2006).
Lützén, Blom, Ewalds-Kvist, & Winch (2010) studied the association between work-related moral stress and moral climate based on surveys with 49 mental health nurses in Sweden. Linear regression indicated that the nurses’ work-related moral stress was mostly determined by the job-associated moral climate. de Veer et al., (2013) evaluated individual and job characteristics associated with moral distress in 365 nurses who work in nursing homes and home care for the elderly in the Netherlands. Bivariate correlation showed a significant relationship between moral distress intensity and job-related stress secondary to nurses perceiving less time available to give care to patients, \( (r = .44, p = .000) \) (De Veer et al., 2013).

Cutbacks and reorganization in health care are undertaken to control costs and improve efficiency. Studies from Canada, Sweden, and Japan revealed how cutbacks resulted in moral distress because the nurses felt constrained in their ability to give care that they felt the patient needed (Brazil, Kassalainen, Ploeg, & Marshall, 2010; Ohnishi et al., 2010; Silén et al., 2008). Brazil et al. (2010) interviewed 18 health care workers from palliative homecare agencies in Canada to determine what caused moral distress. The health care workers revealed that it was distressing when they witnessed patients not having access to appropriate care secondary to budget cuts (Brazil et al., 2010). Other studies have shown that the reorganization of departments based on economic factors can be a factor in nurses’ moral distress (Ohnishi et al., 2010; Silén et al., 2008).

Nurses’ lack of power in the health care hierarchy has been associated with moral distress as reported in the earliest studies on moral distress (Jameton, 1984; Wilkinson, 1987, Corley, 1995). This lack of autonomy and power in decisions that concern patient care continued to be a prevailing theme throughout the early 2000s (Austin et al., 2005). As
reported in a literature review of 39 qualitative studies, unequal power hierarchies that are prevalent in institutions contribute to the experience of moral distress (Huffman & Rittenmeyer, 2012).

Only two studies on different types of empowerment and its relationship to moral distress have been reported. The first study sought to evaluate the relationship between structural empowerment and moral distress in Israel (Ganz et al., 2012), and the second (Browning, 2013) evaluated the relationship between psychological empowerment and moral distress in the United States. Structural empowerment refers to the accessibility of sources of power in the workplace, including information, support, resources, and opportunities (Laschinger, Finegan, Shamian, & Wilk, 2001). There are two types of power: formal, including supervisors, peers, and subordinates; and informal, including flexibility in how the work is to be accomplished and recognition and visibility in the organization. The relationship between these four structures and two types of power determines the amount of structural empowerment (Laschinger, et al., 2001). Perceived level of structural empowerment is measured by the Conditions of Work Effectiveness Questionnaire-II tool (CWEQ-II) (Kanter, 1977; Kanter, 1993; Laschinger, et al., 2001).

Ganz et al. (2012) used the CWEQ-II along with the MDS to measure moral distress levels and structural empowerment in 291 Israeli critical care nurses. Their results showed that nurses perceived moderate levels of structural empowerment, low levels of moral distress frequency, and moderately high moral distress intensity. A weak negative correlation, \( r = -.180, p = .004 \), was found between moral distress frequency and structural empowerment (Ganz et al., 2012). Other international studies have reported organizational
constraints as causative factors in moral distress (Piers et al., 2014; Sunderland, Harris, Johnstone, Fabbro, & Kendall, 2014).

The second study to focus specifically on empowerment explored the relationship between psychological empowerment and moral distress in nursing in 277 critical care nurses (Browning, 2013). Psychological empowerment refers to four personal psychological elements: meaning, competence, self-determination, and perceived ability to impact the workplace (Spreitzer, 1995). Psychological empowerment exists when employees feel that they exercise some control over their work lives and because of this feel more engaged in their work. The perceived level of psychological empowerment is measured by the Psychological Empowerment Scale (PES) (Spreitzer, 1995). In Browning’s 2013 study, nurses’ scores on the MDS and PES showed high levels of moral distress intensity, moderate levels of moral distress frequency, and high psychological empowerment. A moderate and significant negative correlation was found between moral distress frequency and individual responsibility, and between moral distress frequency and ability to impact. Moral distress frequency total scores and ability to impact were also significantly associated. Overall, psychological empowerment scores negatively correlated with moral distress frequency individual responsibility subscale, \((r = -0.213, p = .004)\).

Summing up, it is evident that negative ethical climate contributes to moral distress in nursing across cultural contexts (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). The literature shows that unit and site-specific administrative and general organizational structures impede the nurses’ ability to be moral agents for patients across clinical contexts in the United States and globally. Likewise, both qualitative and quantitative studies support the premise that the power hierarchies that are prevalent in health care institutions contribute
Behavioral Responses to Moral Distress

Research on moral distress suggests that the inability to manage it leads to harmful physical and psychological consequences for the individual nurse, including disengagement and withdrawal from patient care, burnout, and leaving the profession. Oh and Gastmans’ (2015) review of quantitative studies, and Huffman and Rittenmeyer’s (2012) review of qualitative studies, among others, indicate a range of physical suffering from moral distress, including in particular sleeplessness, migraine, and gastrointestinal upset. Austin et al. (2005) along with Epstein and Delgado (2010) have reported psychological consequences such as guilt, sadness, and remorse. de Veer et al. (2013), Dodek et al (2016), Hamaideh, (2014), and Oh and Gastmans (2015) have reported on the association between moral distress, burnout, and leaving the profession. It is evident from these studies that nurses suffer as a response to moral distress, and that this suffering affects the care that they give.

Physical and Psychological Consequences

As mentioned previously, the literature on moral distress reveals that moral residue, the residue that remains when morally distressing episodes repeat over time, relates to physical and psychological suffering in nurses (Webster & Bayliss, 2000). Moral distress can be damaging to the self and to a career (Epstein & Delgado, 2010). The seminal research on moral distress by Jameton (1984), Wilkinson (1987), and Corley (1995) evaluating a total of 135 nurses and described nurses’ physical symptoms as sleeplessness, migraine headaches, and gastrointestinal upset, among others. Psychological suffering was also prevalent. One review of qualitative studies (N = 39) on moral distress, in summarizing
findings, concluded that when nurses cannot work through this stress, they experience anger, loneliness, depression, guilt, anxiety, feeling of powerlessness, and emotional withdrawal (Huffman & Rittenmeyer, 2012). Nurses not only withdraw within themselves but also withdraw emotionally from patients (Huffman & Rittenmeyer, 2012).

The literature contains numerous examples of psychological symptoms described by nurses who have suffered from moral distress, including emotional exhaustion, tearfulness, and anger (Radzvin, 2011); guilt, shame, and self-blame (Rushton, 2006; Guitterez, 2005); depersonalization (Meltzer & Huckabay, 2004); sense of insecurity and low self-worth (Ohnishi et al., 2010); self-criticism (Austin et al., 2005); and guilt, remorse, frustration, and cynicism (Ferrell, 2006). Not surprisingly, studies show that for nurses who experience these emotional responses burnout is often the result (Meltzer & Huckabay, 2004). In recent research (Henrich et al., 2017) had uncovered additional negative emotional consequences such as frustration and compartmentalization of emotions. We have learned that the inability to work through moral residue results in a myriad of unhealthy behavioral responses. These are seen across nursing unit types and cultural contexts (Henrich et al., 2017; Ohnishi et al., 2010). Some of these are physical complaints while others are psychological (Elpern et al., 2005; Huffman & Rittenmeyer, 2012).

**Effect on Patient Care**

A literature review by Oh and Gastmans (2015) of quantitative studies on moral distress summarized that nurses who experience moral distress and continue to work became disengaged and emotionally withdrawn from patient care. According to Hyatt (2017), disengagement from patient care secondary to moral distress is called moral disengagement. Moral disengagement is a process that involves changing one’s ethical actions by changing
one’s moral insight of those actions (Bandura, 1999). Becoming emotionally withdrawn and disengaging from patient care detrimentally affects patients in a number of ways. Gutierrez (2005) asked 12 critical care nurses in one surgical intensive care unit in the Midwest if their experiences with moral distress impacted patient care (Gutierrez, 2005). Over half of the nurses revealed that they requested not to be assigned to care for a patient because of moral conflict. Additionally, one-third of the participants identified a decrease in interaction with patients' families (Gutierrez, 2005).

We know that when nurses reduce their communications with patients, patients feel less safe and less satisfied with their medical experiences (Peleki et al., 2015). Wilkinson (1987) and Corley (1995; 2002) have similarly found that when nurses distance themselves from patients emotionally, they diminish their ability to advocate for patients. This is concerning for many reasons, including the fact that according to Fry et al. (2002), nurses were more likely to withdraw from challenging situations, which is, arguably, when patient advocacy is needed the most. Though no study has directly examined the link of moral distress to patient outcomes, working on moral distress is particularly significant to work on quality practice environments and patient safety initiatives (Pauly, Varcoe, & Storch, 2012). Henrich et al. (2017) described moral distress as placing excess demands on the nurses’ time and attention, leaving less time for nurses to work in a more productive way.

Nurses who experience moral distress and continue to work often become disengaged and emotionally withdraw from patient care. When nurses become emotionally withdrawn and disengage from patient care, they stop communicating with and advocating for patients, so that not only do nurses and their careers suffer, but patients do as well.
**Effect on Nurse Retention and Burnout**

There is strong evidence from quantitative (Oh & Gastmans, 2015) and qualitative (Huffman & Rittenmeyer, 2012) reviews that the way nurses handle burnout secondary to moral distress is by contemplating leaving or actually leaving the profession. Wilkinson (1987) documented a link between retention and burnout secondary to moral distress, reporting that 11 out of the 24 nurses she interviewed left nursing as a result of morally distressing situations (Wilkinson, 1987). This trend is supported over the years in research showing significant correlations between high levels of moral distress and factors such as lower job satisfaction, emotional exhaustion, burnout, and intent to leave an institution (de Veer et al., 2013; Hamaideh, 2014; Henrich et al., 2017). Between 26% and 50% of nurses have reported leaving or changing practice sites due to moral distress (Corley, 2002; Hamric & Blackhall, 2007; Hamric et al., 2012; Wilkinson, 1987). Nurses continue to leave the profession as a result of moral distress (Henrich et al., 2017). There is robust evidence that the way nurses deal with burnout secondary to moral distress is by contemplating leaving or actually leaving their job and/or their career—and given the shortage of nurses, such loss is damaging to the profession and to health care as a whole (de Veer et al., 2013; Hamaideh, 2014; US Department of Labor, 2017).

**Multidisciplinary Moral Distress**

Moral distress is experienced in health care disciplines outside of nursing (Allen et al., 2013; Dodek et al., 2016; Whitehead et al., 2015). Allen et al (2013) Whitehead et al (2015) and Dodek et al (2016) have all reported moderate to high levels of moral distress across disciplines. Similar results were seen in a multidisciplinary study from Sweden (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2004), where physicians, nurses,
pharmacists, dispensers, and pharmacy assistants all expressed having experienced moral distress.

Winland-Brown and Dobrin (2009) interviewed 67 registered nurses and 26 physicians from one U.S. hospital using vignettes reflecting four different ethical dilemmas. Based on their responses, they found that both nurses and physicians experienced ethical conflicts and that an equal number of physicians and nurses experienced moral distress. Other studies have shown moral distress across professions, including Houston et al. (2013), who found that, in their survey of multidisciplinary health care workers, nurses had the highest mean moral distress scores, followed by social workers; residents; MDs; chaplains; pharmacists; and occupational, physical, and speech therapists. Respondents in all job roles consistently rated moral distress intensity higher than frequency (Houston et al., 2013).

Houston et al. (2013) results are comparable to those of other studies (Allen et al., 2013; Dodek et al., 2016; Hamric and Blackhall, 2007; Whitehead et al., 2015). In general, all health care professionals involved in direct patient care appear to suffer moral distress, although nurses consistently rate their moral distress at a higher level.

Overall, factors associated with moral distress in non-nursing health care professionals vary depending on the environment and the circumstances in which the professional works (Hamric & Blackhall, 2007). As mentioned previously, those who work in direct patient care had higher moral distress intensity (Whitehead et al., 2015). The most common dimension intensity of moral distress for physicians, as is true for nurses, involved situations in which caregivers felt pressured to continue what they judged to be unwarranted aggressive treatment (Whitehead et al., 2015). Watching patient care suffer due to lack of
continuity and poor communication were the highest-ranked sources of moral distress for all professional groups (Houston et al., 2013; Whitehead et al., 2015; Dzeng et al., 2015).

Similar to nursing, non-nurses trying to manage moral distress experience dissatisfaction, burnout, and leaving a job and profession (Allen et al., 2013; Dodek et al., 2016; Whitehead et al., 2015). In Whitehead et al. (2015) study, those who left or considered leaving a position had significantly higher moral distress levels than those who never considered leaving, \( p < .001 \). Dodek, et al. (2016) also found the percentages of respondents who indicated that they had considered leaving or had left a job in the past due to moral distress were 52% for nurses, 27% for physicians, and 39% for other health professionals. In a study on physicians only, detachment and withdrawing from patients have also been reported in physicians as behavioral responses resulting from moral distress (Dzeng et al., 2015).

There are myriad sources of moral distress and both nurses and patients suffer as a result (Oh & Gastmans, 2010). Additionally, health care professionals other than nurses suffer from moral distress with similarly damaging consequences (Allen et al., 2013; Brazil et al., 2010; Dodek et al., 2016; Whitehead et al., 2015; Winland-Brown & Dobrin, 2009). Despite the scope and magnitude of the problem of moral distress, only a handful of studies have been performed to test interventions for nurses or other health care providers to prevent or recover from moral distress.

**Measurement of Moral Distress**

Research on moral distress began with an ethnographic study by Jameton in 1984. This and other earlier qualitative research, particularly Wilkinson’s (1987), provided the groundwork for the construction of the MDS quantitative tools by Corley (1995) and Corley
et al. (2001). These tools have subsequently helped to define and quantify the sources of moral distress through dimensions of care (Corley et al., 2001). As discussed previously, the first instrument developed to measure moral distress was the 38-item MDS (Corley, 1995). In 2001, this tool was revised to a 32-item Likert-type scale that measures frequency, intensity, and dimensions of moral distress (Corley et al., 2001). Frequency measures how often morally distressing situations happen, and intensity measures the degree of distress that is caused when it does happen (Corley et al., 2001). To interpret reports on moral distress scores, the total score is frequency times intensity ($f \times i$), which renders the overall level of moral distress.

The root causes are broken into six dimensions—futile care, euthanasia, deception, physician practice, nursing practice, and institutional/work climate—that were created by sub-grouping items within the MDS (Corley et al., 2001). Psychometric testing was performed using a convenience sample of 214 nurses from several U.S. hospitals. Reliability of the MDS factors was estimated by determination of interitem, item-factor, and factor-to-factor correlations as well as by internal consistency estimates for each factor. A two-stage process was used to quantify content validity, and factor analysis was performed (Corley et al., 2001). This research reported the MDS as a reliable and valid measure of moral distress among nurses caring for adults in hospitals (Corley et al., 2001).

In 2012, two new moral distress instruments became available, the Moral Distress Thermometer (MDT) (Wocial & Weaver, 2012) and the Moral Distress Scale-Revised (MDS-R) (Hamric et al., 2012). The MDT is an 11-point visual analog scale that has ranges from 0 to 10 (no distress to worst distress possible). The participants circle the number on the “thermometer” that corresponds with what they are feeling. It is quick and easy
instrument to complete with check boxes listing various root causes so that participants can indicate which are contributing to their distress (Wocial & Weaver, 2012). Benefits of this scale are its convenience and applicability to nurses not working in acute care. It was developed in response to an attempt to evaluate and treat moral residue in real-time and was intended to be used with moral distress that happened within two weeks of administration (Wocial & Weaver, 2012). Psychometric testing on the MDT was performed using a cross-sectional survey design (Wocial & Weaver, 2012). A total of 529 pediatric and adult nurses from three tertiary hospitals from the United States were randomly assigned to complete either the adult or pediatric 2009 version of the MDS scale. Both the adult and pediatric 2009 MDS demonstrated acceptable reliability and support for concurrent validity as measures of MD in hospital nurses (Wocial & Weaver, 2012).

The MDS-R developed by Hamric et al. (2012) is a 21-item Likert scale questionnaire that is an abbreviated form of Corley et al. (2001) MDS. The MDS-R was developed to expand on the root causes that had been identified in earlier research by Elpern et al. (2005) and Hamric and Blackhall (2007). The authors wanted to expand the use of the moral distress scale beyond nursing, including pediatric and adult care practitioners, so six parallel versions of the scale were developed (Hamric et al., 2012). Three versions focus on providers who practice in adult settings: nurses, physicians, and other health care professionals. The remaining three focus on these same provider groups in pediatric settings. Wording changes were made to items to suit clinical situations that applied to other disciplines, but these were kept to a minimum to ensure that the root causes being measured remained consistent (Hamric et al., 2012).
Hamric et al. (2012) tested the MDS-R on 169 nurses and 37 physicians from eight intensive care units in one academic medical center in the southeastern United States in 2011. Their results showed that moral distress was significantly higher for nurses than physicians, although both groups showed a negative correlation between moral distress and ethical climate ($r = -.40, p < .001$). Similar to findings in other research (Corley, 2002; Hamric & Blackhall, 2007), there was a high proportion of nurses (31%) who had left or were considering leaving their current positions due to moral distress (Hamric et al., 2012). Findings from this study add to the evidence of important associations between the moral distress of providers, the ethical climate of health care settings, and the retention of health care professionals. The MDS-R is shown to be reliable and valid in the nursing adult version as well as having construct validity for moral distress in other health care providers, the ethical climate of other work care settings, and the retention of other health care professionals (Hamric et al., 2012). Research using the MDS-R has opened up the ability to study moral distress in multiple disciplines.

**Interventional Research for Moral Distress**

Three studies that tested interventions to treat moral distress were discovered in the literature. The first study evaluated an educational program on moral distress for critical care nurses (Beumer, 2008), and the second reported on a mixed methods pilot of an intervention that educated nurses on end-of-life issues in a burn intensive care unit (BICU) (Leggett, Wasson, Sinacore, & Gamelli, 2013). The third study explored the feasibility of an ethics screening and early intervention tool to help lessen ethical conflict and moral distress in oncology and critical care nurses (Pavlish et al., 2013).

Beumer (2008) applied a pre-test/post-test quasi-experimental design to evaluate the
effect of an educational workshop on 38 critical care nurses from one hospital in the Midwestern United States (Beumer, 2008). Twenty-five staff nurses from one ICU served as the experimental group, and 13 nurses from the critical care float pool who worked in the ICU served as the control group. The goals of the workshop were to define moral distress, identify its signs and symptoms, and state its impact on the individual’s well-being (Beumer, 2008). Those in the experimental group attended a total of five workshops over the course of four weeks, while the experimental group received no education. The workshops consisted of discussions of distressing situations in the intensive care unit, didactic information on moral distress, formulation of an individual plan to reduce stress, and strategies to deal with moral distress in the intensive care unit based on AACN’s 4 A’s Program (Rushton, 2006). Seven to 10 weeks post-intervention, both the experimental and control groups repeated the moral distress level survey and answered a single empowerment question about their perceptions of their ability to speak up during disagreements about futile care (Beumer, 2008).

In both experimental and control groups, the ratings on both of the following statements: “I feel my opinion is valued in decision making about aggressive care for my critically ill patients” and “I feel I can advocate for my patient” increased after the intervention (Beumer, 2008). Anger, frustration, sense of dread, and cynicism decreased after nurses attended the workshop, however, there were similar decreases in the control group as well. There were no differences in either group post-intervention regarding their perception of empowerment to speak up (Beumer, 2008).

This was the first study to evaluate an intervention designed to reduce nurses’ moral distress levels. In addition to measuring moral distress, Beumer (2008) also evaluated
feelings of empowerment after the intervention. The results showed promising results in improving personal feelings of moral distress; however, there was no change in perceived empowerment in either group. Limitations of this study were the small sample size (n = 38) and using untested instruments to measure moral distress and empowerment (Beumer, 2008).

The second interventional study, by Leggett et al. (2013), was a mixed-method, two-phase pilot to examine the effectiveness of a multi-session, end-of-life educational program to lower moral distress and evaluate self-efficacy in nurses working in a burn intensive care unit (BICU) in the United States. Self-efficacy is one's belief in one's ability to succeed in specific situations or accomplish a task (Bandura, 1982). Phase One, the qualitative component, was conducted to construct the educational program. First, the researchers created open-ended questions and conducted interviews with clinicians from four other BICUs in the United States to verify that the content of the educational program was true to the type of stress experienced in burn units. The researchers then applied a grounded theory methodology using constant comparison methods to the interview data to create conceptual categories and themes to inform the intervention design. These conceptual categories were high levels of stress at work, need to be listened to, withdrawal, and isolation of the nurses at work (Leggett et al., 2013).

Phase Two of Leggett et al.’s (2013) study consisted of a separate sample, pre-post design using two validated tools, the self-efficacy scale (SE) and the MDS-R, to measure moral distress in nurses who work in burn units. A separate sample, pre-post design was used because all of these nurses worked in the same burn unit, and it was postulated that information from the intervention might leak to those who did not receive the intervention (Leggett et al., 2013). To control for contamination effect, all thirteen nurses received the
intervention; however only Group A were surveyed before the intervention, and only Group B was surveyed after the intervention (Leggett et al., 2013). The educational intervention consisted of one 60-minute session held every week for four weeks. Sessions included moral distress definition review, case study discussion, root cause discussion, moral distress effects review, and barriers and strategy discussion (Leggett, 2013). The MDS-R and SE Scale were then re-administered again to both Groups A and B six weeks after the intervention was completed. The experimental group (surveyed before and after) had significantly lower MDS-R scores, \((U = 36, z = 2.14, p = 0.032)\), but there were no significant differences in self-efficacy scores between the two groups.

Leggett et al (2013) offered several explanations for the differences between the groups. First, they suggested that both groups had learned a new language as a result of participating in the sessions and because of that were better able to articulate those feelings that had existed all along. Second, perhaps Group B may have been experiencing moral distress all along and were now able to identify and diagnose moral distress in themselves and because of that Group B had a higher moral distress score. Third, they postulated that spending 4 hours over one month talking about and analyzing moral distress raised their awareness contributing to higher levels in Group B (Leggett et al., 2013). Finally, they also noted some demographic differences between the groups in that the nurses who were in Group B had greater work experience. Though these differences were not significant, they discussed the possibility of this difference in work experience contributed to a crescendo effect, where with repeated exposures, the level of moral residue gradually rises (Epstein & Hamric, 2009; Leggett et al., 2013).
At six-weeks post-session, the differences in the scores between both groups were not sustained. Group A had a slightly higher score than previous, and Group B had a slightly lower score, however these were not significantly significant. Leggett et al. (2013) speculated that this occurred because both groups had additional time to process the information that had been learned through the course of the intervention sessions and had become more aware of moral distress. The sample size was small, but the changes in moral distress levels post-intervention and at the six-week follow-up suggest that it would be worthwhile to apply the intervention in a larger sample (Leggett et al., 2013).

The third study, by Pavlish et al. (2013), explored the feasibility of an ethics screening and early intervention tool in oncology and critical care nurses in two urban hospitals in the United States. The purpose of this tool was to help identify at-risk clinical situations and prompt early actions by the nurses to help mitigate ethical conflict and moral distress. The feasibility study used data collected from a previous critical incident study by Pavlish et al. (2011) to examine risk factors and early indicators of ethical dilemmas and conflicts. Twenty-eight nurses attended a pre-intervention, four-hour training session that included background information on ethics terms, review of the American Nurses Association code of ethics, a case vignette, and orientation to the screening tool (Pavlish et al., 2013).

The participants were asked to use the Ethics Screening and Early Intervention Tool in the course of their daily practice for three months. They were instructed to respond to a brief questionnaire on the ethics situation and on the tool’s usefulness for the particular situation each time they used it. After the 3-month testing period, participants completed a final online evaluation of the tool and participated in focus groups to explore the challenges
of using the tool (Pavlish et al., 2013). The nurses stated that even though they felt that the screening tool was beneficial they felt it was risky to use the screening tool and initiate conversation about goals of care. Many nurses admitted that they hesitated to use the tool when approaching physicians or other colleagues (Pavlish et al., 2013).

All three interventional studies for moral distress found in the literature resulted in positive outcomes. The first study helped nurses increase their understanding of moral distress (Beumer, 2008), the second resulted in a significant decrease in moral distress levels after the intervention (Leggett et al., 2013), and the third produced a preliminarily effective early screening tool to prepare nurses and other providers to manage ethically challenging situations (Pavlish et al., 2013). However, none of these studies showed that nurses felt empowered to carry out the actions necessary to ensure their moral agency. There was no increase in perception of empowerment in nurses (even when nurses increased their understanding of moral distress) (Beumer, 2008); there was no improvement in nurses’ self-efficacy (Leggett, 2013); and when presented with a tool that was designed to assist them in managing moral distress, nurses stated they felt powerless to use the tool (Pavlish et al., 2013).

Unequal power hierarchies in institutions contribute to the experience of moral distress in nursing (Huffman & Rittenmeyer, 2012), and it is clear that nurses do not feel more empowered after current interventions that have been designed to work within hierarchical institutions to reduce moral distress and its effects (Beumer, 2008; Leggett et al., 2013; Pavlish et al., 2013). Understanding why that might be requires an understanding of concepts of power, empowerment, oppression, and oppression in nursing.
The Literature on Power, Empowerment, and Oppression

This dissertation is based on three assumptions. The first is that nurses are members of an oppressed group; the second is that nurses’ source of oppression is their lack of power within the health care hierarchy; and the third is that moral distress in nursing is a result of nurses’ lack of power within the hospital hierarchy system. To analyze these assumptions, I briefly discuss the concept of power developed by Michel Foucault (1977) and follow with a discussion of empowerment. Next, I present Ann Cudd’s (2006) concept of social oppression and Iris Young’s (1990) *Five Faces of Oppression* framework in order to describe the conditions that are present in organizational and structural environments that restrain or diminish the power of a social group. The idea of oppressed group behaviors (OGB) will be explicated with examples of OGB in nursing. Finally, the linkages between power, oppression, and moral distress will be presented.

**Power**

In order to understand oppression, one must first understand how power and empowerment work in opposition to one another. The concept of power that aligns best with the research in this dissertation is that of French philosopher Michel Foucault. Foucault was a French philosopher whose work spanned many decades. His work touched on many areas of philosophy, but in his middle to late work (1970-1984), he examined the relations between knowledge, power, and human subjects (Foucault, 1977; Gallagher, 2008). Foucault’s (1977) view of power is postmodern in that he does not consider power to reside in the sovereign control of one group of people by another group of people. Instead, Foucault (1977) argued that the real exercise of power consists in the more diffuse operation of thoughts, attitudes, and social relationships and is dependent on culture, place, and time.
Influenced by Nietzsche’s ideas about the linkage between knowledge and power, Foucault (1982) believed that where knowledge circulates in the form of discourse—the public and even private structures of thinking and believing—there is power, which in turn generates more knowledge (Sadan, 1997/2004). According to Foucault, the everyday practices such as education, bureaucracy, production, and distribution of consumer goods, even ideas such as health and philanthropy are instantiations of power that come to influence and guide people’s thoughts and behaviors. People, merely doing their jobs or living their lives within these fields of activity and institutions enact and enforce power, though rarely do they understand themselves as agents of power (Foucault, 1977). Foucault did not intend to pigeonhole the concept of power, assigning it to a fixed definition but rather considered it to be a flexible concept.

Sadan (1997/2004) has usefully summarized Foucault’s (1977) basic ideas about power in six assumptions. The first assumption Foucault made was that power is not a thing, award, or scheme. Rather, power is connected with social events and practices that are performed in everyday life (Sadan, 1997/2004). Second, as Sadan (1997/2004) explains, power relations are mobile and not equal, there is no balancing of power in relationships, only continual, dynamic shifting. Third, since power is not a thing, it cannot be captured in a set of rules or a hidden historical pattern. This is why it is important to understand how power operates minutely in social institutions, on a routine, everyday level. Fourth, power has a direct and an indirect role in social life: it operates not just from the top down but also from bottom up. Indeed, power is at its strongest in institutions such as schools, hospitals, and prisons where all aspects of the institution provide a medium for the generation and movement of power—through rules, creeds, standards, mission statements, the physical
arrangement of space and communication flows, and the cultural codes. At the same time, Foucault (1977) warned against identifying power as a characteristic of an institution or structure, because power is not a quality of an institution but an emanation of the relationships in it (Sadan, 1997/2004). The positive aspect of power is called productive power because there are efficient results produced by knowledge and expertise—for example, in the domains of economy, industry, and science. Foucault’s fifth assumption was that power relations are continuous and ubiquitous in a given society at a given time. No one is completely outside of power and no one is above and controlling it (Sadan, 1997/2004). Sixth, Foucault assumed that, even where control and authority do exist, those who exercise control simultaneously remain subject to power in multiple ways (Sadan, 1997/2004). Foucault’s ideas about the diffuseness and ubiquity of power, its embeddedness in everyday relationships, are useful because they underscore how people can become agents of power through thoughts, behaviors, and circumstances. Power, in this sense, is experienced as something that is part of life and is not sought after, owned, or coveted (Foucault, 1977).

Conversely, many people still consider power as a thing to be sought and protected. Why do people want to have and keep power? Keltner, Grunfeld and Anderson (2003) believed that power is coveted because it provides those that have it with many benefits such as safety, control, comfort, freedom, choice and entitlement. It also contributes to one’s feeling important because it does uphold that belief by producing results (Keltner et al., 2003). Since these assets add to a positive day-to day life, it is understandable why power is sought after. Seeking power is an act performed through personal behavior, thoughts, and feelings in the political, social, and interpersonal worlds of human life (Keltner et al., 2003).

Power is maintained in other ways as well. Keltner et al. (2003) points out,
somewhat similar to Foucault (1977), that power is not uniform, that not all individuals in
dominant groups and not all dominant groups all the time behave in oppressive ways toward
others. But, as Johnson (2005) describes, there are forces that have existed over generations
that allow individuals in certain groups historically to maintain power over others. The
groups with power are referred to in most of this literature as dominant. Members of
dominant groups inadvertently, often unconsciously, continue to benefit from cultural and
structural advantages that developed over time (Johnson, 2005). In contrast, those who are in
non-dominant groups continue to encounter social and economic constraints or obstacles,
which can be deeply embedded in a culture or community—in its language, practices, and
beliefs and in the very structures of its social order. The experience of continually meeting
these obstacles, dismissals, exclusions, definitions, choices or pathways—impacts the
thoughts and feelings of the non-dominant. The non-dominant groups eventually pick up
behaviors that both diminish and perpetuate the oppression (Keltner et al., 2003).

What happens when there is resistance to power relations in a social order?
According to Wickham (1986) there is a two-sided face to resistance to power. The
resistance itself confirms the power network and reiterates its boundaries, because otherwise
there wouldn't be any reason to resist. On the other hand, beginning any resistance brings
about a change in the power relations (Wickham, 1986). Minson (1980) explains that power
is the force that *produces* the resistance, determines its place, and then administers the
conditions that the resisters are asking for. The powerful create the environment for
preventing more threatening and subversive forms of resistance. In other words, through
their responses, the powerful discipline and constrain, keeping more dangerous and
subversive resistance at bay (Minson, 1980).
In review, Foucault’s (1977) concept of power aligns with the notion that power is not a quality of an institution but a product of the relationships in it. It is the everyday practices of people doing their jobs or living their lives within fields of activity and institutions that enact and enforce power (Foucault, 1977; Sadan, 1997/2004). Keltner et al (2003) believed that power is sought after because it provides those who have it with safety and control and contributes to their importance. Also relevant is Johnson’s (2005) description of forces that have existed over generations that allow individuals in certain groups historically to maintain power over others. In contrast, those who are in non-dominant groups continue to encounter social and economic constraints or obstacles, which can be deeply embedded in a culture or community in its language, practices, and beliefs and in the very structures of its social order (Johnson, 2005).

**Empowerment**

Power is, as Foucault (1977) acknowledged, a dynamic entity, in that power is not stagnant but always being taken, given away, and shared (Sadan, 1997/2004). According to Sadan (1997/2004) empowerment means a switch from a state of not having power or control over one’s life, fate, and environment to a state of more control over these. There are three social conditions that are affected by empowerment: individuals’ feelings and capacities, the collective consciousness of groups, and professional practice. Hence, growth from empowerment may be seen in individual empowerment, collective group empowerment, or organizational empowerment (Sadan, 1997/2004). Manojlovich (2007) suggests that empowerment for nurses also consists of three components: an inner belief in one's ability to be empowered, a workplace that has the necessary structures in place to promote empowerment, and an understanding that there is power in caring that nursing as a
profession provides.

In this dissertation all three—individual, organizational, and group empowerment—are evaluated. Individual empowerment is defined as psychological empowerment, which is the psychological state that employees must experience for empowerment interventions to be successful. It is the state in which employees feel that they can exercise some control over their work lives that positively affect the relationship between them and the organization for which they work (Spreitzer, 1995). Organizational empowerment is defined as structural empowerment, which is the proximity of the employee to factors such as information, support, resources, and opportunities. These factors are considered sources of power in the workplace, so those that have close proximity to them have more structural power (Kanter, 1977; Kanter, 1993; Laschinger, Finegan, Shamian, & Wilk, 2001). Group empowerment is defined as the successful movement of each group through the intervention sessions of critical reflection, critical motivation, and critical action whereby there is group recognition of the oppressive forces causing moral distress and group creation of action projects to change those forces (Freire, 2016).

**Oppression**

Three theoretical interpretations of the concept of oppression will be applied in this dissertation. First, I apply Ann Cudd’s (2006) concept of social oppression. Second, a framework developed by Iris Young (1990) will be used to clarify and expound on examples of oppression in nursing. Third, Paulo Freire’s (1995) work will be used as a guide to describe oppressed group behaviors in nurses, and Freire’s *Pedagogy of the Oppressed* will provide the theoretical framework for the intervention that was developed in this study.
Anne Cudd and Social Oppression

Ann Cudd (2006) is a professor of philosophy who has focused on themes of oppression, economic inequality, and gender in her work. Cudd proposed a theory of social oppression as structured harm, or harm that is perpetrated on social groups by other groups through social institutions. For every social group that is oppressed, Cudd (2006) argues, there is an associated social group whose members benefit from the oppression. Cudd describes being perplexed as to why such oppression happens, and more importantly, how it persists. Her answer lay in her recognition that the oppressed unknowingly joined in their own oppression. How this worked, according to Cudd, was first through the intimidating use of direct force against the oppressed, followed by subsequent, secondary economic, and psychological pressure. These latter forces are especially subtle because they hide the oppression from both the oppressed and the oppressors, as well as from others who might be compassionate to the situation of the oppressed. The oppressive process takes form as self-generating cycles that are, similar to what Foucault described, enabled by social institutions, such as communities, schools, ethnic or cultural groups, families, and the government (Cudd, 2006).

The sequence of events that leads a group toward oppression begins with one group forcefully dominating another group, usually by exerting economic power over subordinates. The subordinate group (the oppressed) responds by choosing from the limited options offered to them by the oppressors, in order to survive the immediate situation (Cudd, 2006). Over a period of time, Cudd explains, the oppressed gradually find that their own beliefs and aspirations are shaped by these oppressive conditions. As succeeding generations adopt the adapting mechanisms of the previous group, they come to believe in the authority of the
controlling group and their own inferiority. Cudd argues that the oppressed come to believe that they suffer personal weaknesses, causing shame and low self-esteem. By this time, the unequal power relationships between oppressor and oppressed are no longer characterized by force; they become a norm or standard way of life (Cudd, 2006).

The oppressed become dependent on the dominant social groups for support and leadership, and the power difference has become embedded, a situation which Cudd (2006) describes as a chain with interlocking links. To break away from oppression, not only would these interlocking links need to be broken, the oppressed would also need to be set on a course towards independence (Cudd, 2006). Breaking away and gaining independence is a very difficult thing to do, since oppression has been embedded in the oppressed people’s psyche (Cudd, 2006). As will be discussed later in this chapter, one way of breaking away is embodied in Paulo Freire’s (1995) *Pedagogy of the Oppressed*, which presents an educational approach that was designed specifically to empower oppressed people and move them towards freedom.

**Oppression in Nursing**

**Sequencing of Oppression in Nursing**

As mentioned by Ann Cudd (2006), the sequence of events that leads a group toward oppression begins at some point in time. There are a number of episodes in nursing’s historical and cultural background that contributed to the development of oppression in nursing. These episodes include nursing’s origin as a religious calling (Carson, 1989; Tyler & Raynor, 2006); its long, evolving relationship with medicine (Fletcher, 2006); the impact of that relationship on early nursing education and hospital work (Nelson, 2001); and nursing’s gendered dimension as female work (Farrell, 2001; Manojlovich, 2007; Rafferty, 2001; Smith, 2006).
Previously, nursing was closely aligned with religion, enabling it to be viewed as a career of service, vocation, and sacrifice (Carson, 1989; Rafferty 2014). The earliest professional nursing was performed by members of various religious orders in the role of taking care of the poor and homeless; early forerunners in nursing were women associated with religious organizations—Elizabeth Seton–The Sisters of Mercy–Florence Nightingale (Carson, 1989; Rafferty, 2014; Tyler & Raynor, 2006). Nursing schools were often housed within religious denominations, reinforcing this affiliation with religion (O'Brien, 1999). The early ideals of religious service including charity, devotion, and sacrifice are largely antithetical to the concept of power in that they are centered around service to others for altruistic reasons without expectations of benefit in return (Carson, 1989).

The education and training of nurses was influenced at the turn of the 20th century by the creation of modern hospitals (DeMarco & Roberts, 2003; Matheson & Bobay, 2007). Physicians, who typically led these hospitals, needed nurses to support them in taking care of the sick, and to that end, they created and controlled the nursing educational systems. This control laid the foundation for what has been characterized as an authoritarian and autocratic relationship between doctors and nurses (DeMarco & Roberts, 2003; Matheson & Bobay, 2007). Modern nursing education has preserved these rituals of tradition and oppression in terms of what is taught and how it is taught (Tyler & Raynor, 2006), for example doctors give orders to nurses, and nurses fill them.

According to Fletcher (2006), nursing has also been affected by the broader social and cultural norms supporting traditional power imbalances around gender. In the early 20th century, the traditional female role of caregiver supporting medicine was closely linked to
the typical woman’s experience of supporting men in everyday life (Fletcher, 2006).

Manojlovich (2007) considers that power has been seen as an outcome of masculinity and in direct opposition to caring, which is seen as the essence of nursing and traditionally aligned with femininity. Nursing is still a predominantly female profession, with 91% female workforce (National Center for State Board of Nursing [NCSBD], 2017). Nurses may suffer even more from the forces of oppression because they are socialized as both nurses and women, both historically subordinate groups (De Marco, 1997; Roberts, 2000; Hutchison et al., 2006).

Hughes and Clancy (2009) point out that this historical background has had an effect on how nurses are situated in the hierarchy of hospitals today. Likening it to the idiom of low man on the totem pole or the least important person in an organization or group, Hughes and Clancy (2009) call this the totem pole effect with nurses at the bottom of the totem pole in the health care hierarchy. This effect is exemplified in general terms by Kagan (2018) who describes the U.S. health care system as an industrial biomedical complex focused on disease, intervention, and cost containment and designed to answer physicians’ and administrators’ needs. In contrast, nurses are not included in the strategic planning for care yet are expected to execute the actual care and management of patients (Kagan, 2018).

Another way to visualize the hierarchical pattern of power in a hospital setting is to think of nurses as part of a larger health care team organized according to a hands and heart versus head hierarchy. While all of health care professionals work together, the nurses are often viewed in terms of compassion and hands-on care and are thus viewed as the ones who carry out the orders of those who do the thinking. This puts them lower on the totem pole (Kagan, 2018). As nurses view it, they value the healing, growth, and safety of individuals,
families, and communities. They teach, comfort, advocate for, and provide emotional and physical monitoring and the intervention necessary to protect patients and promote health and healing. However, as Sheridan-Leos (2008) has argued, caring, which is central to nursing, is often treated as less important than curing, helping to instill in nurses that the medical model is dominant. This lower ranking sustains the oppression and, as will be discussed, has an effect in bullying, stress, and the care provided to patients (Hughes & Clancy, 2009).

It is important to clarify that identifying nursing as an oppressed group should not be interpreted as assigning blame or labeling nurses as weak, but, rather as seeking to define and evaluate a problem and work for change (Roberts, DeMarco, & Griffin, 2009). Buresh and Gordon (2000), non-nurse feminist writers, have long encouraged nurses to develop a voice of action. This voice is important so that nurses do not continue to suffer from the self-perpetuated submission which has kept nurses in their dependent and oppressed position (Buresh & Gordon, 2000).

To summarize, the sequence of events that led to nursing’s subordinate position in the health care hierarchy includes their origin as a religious calling (Carson, 1989; Tyler & Raynor, 2006); a long, evolving relationship with the medical profession (Fletcher, 2006) and the impact of that relationship on early nursing education and hospital work (Nelson, 2001); and nursing’s gendered dimension as female work (Farrell, 2001; Manojlovich, 2007; Rafferty, 2014). As Cudd (2006) has described, once the sequence of events that leads a group toward oppression begins, these situations become a standard way of life and are engrained in the self-understanding of the oppressed. In alignment with Cudd (2006), Hutchinson et al. (2006) asserts that oppressed group behavior supports unequal power
balances in the workplace and contributes to nurses’ oppression. Ahead, Young’s (1990) *Five Faces of Oppression* provides a framework for further discussion and evaluation of oppression in nursing.

**Iris Young and the Five Faces of Oppression.**

The second theoretical influence in this dissertation is that of Iris Young. Young was an American political theorist and feminist who focused on the nature of justice and social difference at the University of Chicago. Her conceptualization of oppression was influenced by the social liberation movements of the 1960s and 1970s. Young (1990) viewed oppression as a structural concept that, similar to Cudd’s understanding (2006), was embodied in the systemic restrictions that groups experienced through embedded norms, habits, and images.

According to Young’s (1990) definition, oppression occurs in the commonplace interactions within organizations in the normal practices of everyday life. In systemic oppression, it is not necessary that oppression be intentionally or deliberately practiced by one group on another (Young, 1990). This notion aligns with Foucault’s modern view of power in that he believed that unexamined or unconscious actions of many individuals contribute daily to maintaining and reproducing oppression. Foucault stressed that these people are usually merely doing their jobs or living their lives, and they do not understand or consider themselves as agents of oppression (Foucault, 1977).

Because Young’s (1990) view of oppression refers to organizational or structural trends that restrain or diminish the power of a social group, it is important to understand what a social group is. A social group is a collective of people that is set apart from at least one other group by social norms, practices, or ways of life (Young, 1990). An example of a
social group would be the Amish or the Hasidic Jews, since their social norms or practices set them apart from most other groups. A social group experiences oppression, according to Young (1990), under five conditions: exploitation, marginalization, powerlessness, cultural imperialism, and violence. Oppression can occur in all, multiple, or just one of these five conditions (Young, 1990).

Young (1990) defines the first condition, exploitation, as taking advantage of the labor of one social group to benefit another. As DeMarco and Roberts (2003) pointed out, at the turn of the 20th century, nurses’ educational systems and work in hospitals were exploited and controlled by physicians. This was not unusual and is typical of the early 20th century female role of caregiver, supporting men in everyday life (Fletcher, 2006). Nurses also experience Young’s second condition, marginalization, a process whereby someone or some group is pushed to the edge and given less importance. Young argued that marginalization is one of the most dangerous forms of oppression because it permits a person or group to be viewed as insignificant, depriving them of recognition. As Fanon (1963) observed, people who are marginalized exist on the fringes of their own group but still do not belong to the dominant group. As Roberts, DeMarco, and Griffin (2009) share, nurse managers are a good example of marginalization because their promotion over other nurses is often curated by powerful physicians and administrators, a situation that does not make them equals of those who promoted them but makes the nurse manager more likely to promote the institution’s agenda rather than nursing’s agenda. Matheson and Bobay (2008) write that nursing leaders often remain on the fringes of both nursing and the hospital power structures because of this situation.
Young’s third condition or face of oppression is powerlessness. Young (1990) describes powerlessness as an inability to develop one’s own capacities to their fullest, a lack of decision-making power in one’s work life, and exposure to disrespectful treatment because of one’s status. In a condition of powerlessness, people must take orders but do not give them (Young, 1990). According to Young, a condition of powerlessness can mean the absence of opportunity to develop and grow. Young’s fourth category is cultural imperialism, or the way a dominant group’s norms become defined as the norm or standard for all groups to follow. Anyone operating in ways that fall outside the dominant group’s sphere is seen as other: variously invisible, devalued, and objectified (Young, 1990). Nursing has struggled with medicine’s control for many years because physicians had great influence in early education of nursing and the establishment of modern hospitals (Nelson, 2001). Medicine continues to dominate the vocabulary, philosophy, scientific standards, and practice standards in the world of health care—so that, even when not present, they seem to dominate the culture of health care (DeMarco & Roberts, 2003).

The fifth and final condition associated with oppression by Young (1990) is violence. Violence against a member of an oppressed social group can be overt (hitting, pushing, tripping) or covert (shunning, starting rumors, eye-rolling, marginalization), and it can be vertical (practiced by the dominant group against members of the oppressed group) or horizontal (by members of an oppressed group against one another). Vertical violence—both overt and covert—has long been practiced against nurses by physicians and other dominant members in the hospital (Araujo & Sofield, 2011; Young, 1990). According to a summary on workplace violence in nursing (Araujo & Sofield, 2011), vertical violence is an ongoing problem that is not new and is best displayed by the nurse-physician relationship, where
nurses have long been yielding power to physicians in their communication. Vessey, DeMarco, Gaffney and Budin (2009) surveyed 303 nurses to evaluate the extent of bullying and vertically violent behavior towards staff nurses. The sample was obtained from an internet web-linked survey that was attached to an article about nurses bullying in the national bi-weekly news magazine Nursing Spectrum. Seventy percent of staff nurses reported having been the victim of vertical violence from sources that included senior nurses, charge nurses, and physicians. Bullying behaviors most often described were isolation, exclusion, and verbal abuse (Vessey et al., 2009).

Horizontal violence, as mentioned earlier, is practiced by members of an oppressed group against one another (Young, 1990). Both Freire (1995) and Fanon (1963) identified horizontal violence in people who are oppressed, noting how horizontal violence can be a response to feelings of powerlessness. According to Hutchinson, Vickers, Jackson, and Wilkes (2006), horizontal violence is pervasive in nursing. Horizontal violence includes both explicit (infighting, sabotage, scapegoating, and criticism) and implicit (ignoring, shunning, and gossiping) behaviors (Griffin, 2004). An astounding one in three nurses reportedly leave their positions because of bullying (Griffin, 2004).

Young’s framework has previously been used by Dong and Temple (2011) in a concept analysis on oppression in nursing and by Dubrosky (2013) to discuss oppression in nursing. Dong and Temple (2011) concluded that oppression is negative, harmful, and unjust and that evaluating it though Young’s framework may lead to resistance and change. Dubrosky (2013) asserted that Young’s framework clearly lays out the ways in which nurses are oppressed in today’s health care system and allows nursing to find its voice in the bigger world of the health care system. Young’s (1990) framework of oppression offers a set of
definitions for and relationships between concepts that have direct, documented relevance to nurses as a social group.

**Oppressed Group Behaviors**

Freire (1995), along with several other theorists including Fanon (1963) and Memmi (1965), were among the first to identify a set of behaviors called oppressed group behaviors (OGB). OGBs, including self-hatred/low self-esteem, assimilation, marginalization, submissive–aggressive syndrome, and horizontal violence, constitute learned outcomes of unequal power dynamics and often characterize survival in an oppressive situation (Fanon, 1963; Freire, 1995; Menni, 1965). As described by Freire (1995), the first OGB is self-hatred and low self-esteem, which develops over time as the oppressed come to feel contempt for themselves. Next, those in the oppressed group who want to succeed feel that they need to change and become more like the oppressors in a process called assimilation (Memmi, 1965).

When the oppressed attempt assimilation, instead of inclusion and recognition, they often experience marginalization. Freire (1995) argued that being marginalized actually results in members of the oppressed being situated on the fringes of their own group, while at the same time not being accepted as members of the dominant group. The oppressed may find that being assimilated results in some temporary rewards, but in reality, their *marginal* position actually benefits the oppressor group more than their own (Freire, 1995).

Additionally, the oppressed display the dichotomous temperaments of being both submissive and aggressive when confronted by authority (Freire, 1995). Submission or silence in the face of authority is a result of fear and low self-esteem that often turns into aggression and
anger. Finally, anger in marginalized persons is manifested in behaviors towards their own group, resulting in horizontal violence (Fanon 1963; Freire, 1995; Menni, 1965).

Oppressed people are often silent in the midst of these behaviors because, as DeMarco and Roberts (2003) have pointed out, silencing is a learned behavior in which a person is rewarded for suppressing their feelings and needs in an effort to survive powerlessness. In addition, it is difficult for the oppressed to effect any change in the status quo because those who are oppressed lack solidarity, or the feeling that there is a group that can come together for change (DeMarco & Roberts, 2003).

**Oppressed Group Behaviors in Nursing**

As mentioned previously, the OGB are self-hatred and low self-esteem, assimilation, marginalization, submissive–aggressive syndrome, and horizontal violence (Fanon, 1963; Freire, 1995; Menni, 1965). The first notion that nurses displayed OGB was suggested by Roberts (1983) when she described horizontal violence/workplace bullying in nursing through the lens of nursing as an oppressed group. Since that time, evidence of lateral violence and other OGB in nurses has been reported regularly in the literature (Castronovo, Pullizza, & Evans, 2016; Clark, Plender, Kenski, & Cardoni, 2013).

In 1997 Fulton sought to understand British nurses’ concept of empowerment. Using the work of Paulo Freire and Jurgen Habermas as theoretical frameworks, four focus groups with 16 nurses were asked open-ended questions. Four major categories emerged from the data: empowerment, having personal power, relationships within the multidisciplinary team and feeling right about oneself (Fulton, 1997). Out of these categories, three themes were found that are indicative of oppressed group behaviors. The first theme was that nurses were trying to assimilate with the more powerful physician to gain power, the second theme was
bullying and horizontal violence by the nurses, and the third theme was low self-esteem and self-doubt in the nurses (Fulton, 1997).

Reports of OGB have also been revealed in research on moral distress in nursing. In the previously discussed studies by Gutierrez (2005) and Zuzelo (2007), which evaluated the effects of moral distress on burnout in critical care nurses, researchers found evidence that nurses felt silenced and experienced low self-esteem specifically in conflicts involving morally distressing patient care situations. Maiden, Georges, and Connelly (2011) found evidence of OGB when they examined the relationships between moral distress, compassion fatigue, and perceptions about medication errors in 205 critical care nurses. Nurses described being blamed and marginalized when medication errors occurred. This marginalization and blaming led them to assert that the work environment blamed them for systemic problems (Maiden et al., 2011).

As in other oppressed groups, nurses display OBG through silencing and passive-aggressiveness (DeMarco & Roberts, 2003; Hutchinson, Jackson, Vickers, & Wilkes, 2006; Roberts 1983). Laabs (2011) studied 27 new graduate nurses via online survey from one university in the United States to determine how prepared they were to perceive and manage challenges to their moral integrity. The 27 participants indicated that they thought a nurse was expected to set aside their values and beliefs and do what others ask. The new graduates not only reported feeling pressured from their colleagues to be silent in the sense of not asserting their values, but they also felt that they were expected to be silent about their contributions to patient care (Laabs, 2011). These two types of coerced silence are related to nurses’ submissiveness and workplace practices that reward obedience and conformity (Laabs, 2011).
Moreland and Apker (2016) explored how nurses manage conflict and stress, including methods of conflict communication. Open-ended surveys were conducted with 135 nurses at one large research hospital and were qualitatively analyzed through a grounded theory process. The results showed disrespectful conflict communication occurred in both explicit and implicit ways. Tied in with explicit horizontal violence were behaviors characterized by passive-aggressiveness, incivility, gossiping, and mocking; going behind others’ backs; and minimizing professional contributions (Moreland & Apker, 2016). Some nurses in this study noted that their peers passively accepted disrespectful communication actions as the norm and that nurses did not support each other (Moreland & Apker, 2016).

Seeking to evaluate what contributed to Canadian staff nurses’ marginalization in the health care system, Daiski (2004) asked broad open-ended questions in interviews with 24 nurses. The nurses reported bullying practices and abuse along existing hierarchies within nursing. Overall, the nurses felt they received little respect from physicians and nursing managers and that they remained largely excluded from decision-making processes. As is the norm in oppressed groups, when given the opportunity to represent their patients’ wishes for their care, the nurses reported that they often remained silent (Daiski, 2004). As Freire (1995) reported, silence to authority by the oppressed person is a result of fear and low self-esteem.

Studies evaluating horizontal violence and bullying behaviors have uncovered a multitude of OGB in nurses. Covert or passive aggression was found McKenna, Smith, Poole and Coverdale’s (2003) study that sought to determine the prevalence of horizontal violence experienced by nurses in their first year of practice in New Zealand. Over half reported being undervalued by other nurses (58%), with over a third (34) saying they had
had learning opportunities blocked. Additionally, more than one third felt neglected (31%), and more than one third felt under-valued (34%). Likewise, Croft and Cash (2012) conducted a focus group study to explore Canadian nurses’ experiences of bullying and lateral violence. In the focus groups, 20-24 participants were asked questions about their perceptions of the workplace atmosphere and what they thought contributed to workplace lateral violence (Croft & Cash, 2012). Themes consistent with marginalization and lateral violence were uncovered (Croft & Cash, 2012). Two studies from Australia also found bullying behaviors such as compliance and silence (Rodwell & Demir, 2012), along with personal attack, isolation, intimidation, degradation, and erosion of professional competence and reputation (Hutchinson, Vickers, Wilkes and Jackson (2010),

To review, since oppressed group behaviors in nursing were introduced by Roberts in 1983, we have learned that nurses suffer from a variety of oppressed group behaviors that include silencing and low self-esteem (Guitterez, 2005; Zuzelo, 2007), assimilation and self-doubt (Fulton, 1997), marginalization (Maiden et al., 2011), and the most often referenced, bullying and lateral violence (Croft & Cash, 2012).

**Linking Moral Distress Power and Oppression**

Austin et al. (2005) has written that nurses are responsible for the care of patients but have had little authority over that care. In the hierarchical hospital system, nurses face challenges in maintaining autonomy and power in decisions that concern patient care (Elpern et al, 2005; Epstein & Delgado, 2010). In general, caring, which is central to nursing, is treated as less important than curing, and this reinforces a subordinate role for nurses in health care (Sheridan-Leos, 2008).

When this lack of power prevents moral agency in ethically or morally challenging
patient care situations, moral distress can occur (Jameton, 1984). There is strong evidence that the unequal power hierarchies that are prevalent in institutions contribute to the experience of moral distress (Huffman & Rittenmeyer, 2012). Nurses who have experienced moral distress emphasize that they have experienced considerable struggle trying to effect change in the face of organizational constraints. Often, nurses who attempt to stand up for themselves in morally challenging patient care situations report having met with punishment or loss of employment (Peter et al., 2004; Varcoe et al., 2012a).

Because of the sequence of events that leads to oppression in nursing (Cudd, 2006) and because of nursing’s lack of power in the hospital hierarchy work environment, nurses can be defined as an oppressed group. Like other oppressed people, nurses exhibit oppressed group behaviors (OGB) and often lack insight into their oppression, making it unlikely that they will overcome it on their own (Freire, 1995). To find a solution to moral distress in nursing requires examining the history and causes of oppression (Ridner, 2004). Paulo Freire’s *Pedagogy of the Oppressed* (1995) provides both a framework for understanding the oppressive conditions that cause moral distress in nursing and a framework for guiding nurses to an empowering response.

**Theoretical Framework**

Paulo Freire’s (1995) *Pedagogy of the Oppressed* provided the theoretical framework for the intervention that was developed in this study. Freire’s (1995) philosophy about oppression is described below, followed by a detailed discussion of his pedagogy that includes components such as the animateur role, problem-posing education, and the learning stages that are specific to problem-posing education. There follows a conclusion with a description of Freire’s (1995) conscientization, which names a process that allows for the
belief in human equality and dignity and encompasses cultivating awareness about and acting to change the conditions of social injustice that lead to inequity (Freire, 1995).

**Oppression and Paulo Freire**

Freire linked oppression to the concept of dehumanization, the psychological process whereby people view each other as less than human and thus not deserving of moral concern (Maiese, 2003). Freire (1995) believed that oppressed people share a lack of awareness about their situations and are unable to describe their reality because of their social positions and unexamined social beliefs. This lack of awareness prevents them from acknowledging the conflicts in their personal experience and the systems of power over them (Freire, 1995; Hernandez & Dolan-Delvecchio, 2005). According to Freire (1995) the unequal social relations that are part of oppression create what he calls the culture of silence that instills a negative, passive and suppressed self-image onto the oppressed. Because of this, the oppressed must acquire a critical consciousness in order to recognize that this culture is created intentionally to keep them down (Freire, 1995).

Freire (1995) believed that there is a conflict in the oppressed person’s relationship with and understanding of freedom. The conflict is that, without freedom they cannot live authentically, but at the same time, they fear this freedom. Freedom requires the oppressed to discard the image of victim and replace it with independence and responsibility. In order for this to happen, people must recognize the causes of oppression and be willing to transform their state of affairs (Freire, 1995). Liberation from oppression must come from within the oppressed group itself. The suggested way to accomplish this is to guide people who experience oppression to recognize their situation through their own observations, critical reflections and actions (Freire, 1995).
As seen in OGB and alluded to by Cudd (2006), oppressed groups have learned to turn on each other, reinforcing the negative stereotypes that continue the cycle of oppression. In order to counteract this cycle of oppression, Paulo Freire (1995) developed an educational intervention to help prevent oppressed people from self-sabotage. Freire understood that teaching people who are oppressed would require a pedagogical approach that would help learners recognize the existence and causes of their oppression while simultaneously assisting them in changing their reality.

**Pedagogy of the Oppressed**

In the late 1950s, Freire initiated a literacy program for an oppressed group of sugarcane workers and slum dwellers in Brazil. He based this program on conclusions he reached from reflecting on his own childhood experience living in poverty and from teaching very poor and oppressed groups. Freire’s observations and experiences led him to conclude that oppressed people were often unaware of the power imbalances in their lives because they interpret the world through the oppressor’s eyes. He felt that this lack of awareness prevented them from recognizing the systems of power over them (Freire, 1995; Hernandez & Dolan-Delvecchio, 2005). Because he was an educator, Freire was especially interested in the instance of oppression and exercise of power that existed in the relationship between teachers and students, though he always saw that relationship as both an extension and example of oppression in other social relationships. After examining his experience, Freire developed an educational system that proposed a new relationship between teacher, student, and society.

The alternative educational pedagogy that Freire (1995) introduced was called pedagogy of the oppressed and is based on the principle that humans have the ability to change by
reflecting on the conditions of their lives. In order to teach his students—mainly rural sugar cane workers—to read, Freire started what he called culture circles, which used drawings and paintings to encourage students to think critically or questioningly about the conditions of their lives in the hopes of shaping their own future. These culture circles progressed into literacy classes where he used words that represented the socially challenging issues about which his students felt passionate. By encouraging students to reflect on the condition of their lives, Freire was able to help them see that they were able to evaluate their futures differently (Freire, 1995).

How this happens is explained by Nina Wallerstein and Elsa Auerbach, academics who are experts in community-based and participatory literacy research and Freirean interventions. Their guidebook Problem-Posing at Work: Popular Educators Guide (Wallerstein & Auerbach, 2004) was written for educators from diverse fields who are interested in critical reflection and social action. As interpreted by Wallerstein and Auerbach (2004), Freire understood that the key to liberation from an oppressed state is the awakening of critical awareness and the thinking process of the individual in social exchange with others. Hence, most of Freire’s methods function to prompt such awakening and exchange. Wallerstein and Auerbach (2004) point out that Freire’s use of socially-linked words motivated his worker-students to start thinking in concrete, personally familiar terms of the social root causes of problems and how they could effect change. These familiar terms turn into what is called generative themes (Freire, 2016). Since the students generated themes as a group through the culture circles, their awareness was built communally and laterally rather than top down through information passed from teacher to student (Wallerstein & Auerbach, 2004).
The reason Freire (1995) changed his teaching methods for his oppressed pupils was he felt that the traditional classroom-type lecture education between student and teacher, which Freire called banking education, was actually a form of oppression. In contrast to a banking education approach, Freire’s pedagogy is based on the principle that learning should be a liberating process, that humans have the ability to change by reflecting collectively on the conditions of their lives, and that no one is destined to be oppressed (Freire, 1995). Freire called his method of education problem-posing education.

**Role of Animateur**

Prior to discussing problem-posing education and its learning stages, it is important to understand the unique role of the program leader and how this role contributes to the success of the intervention. Called the animateur, as described by Wallerstein and Auerbach (2004), this person functions as a motivator, engaging and guiding students through the three phases and five learning stages of the educational process. Since problem-posing education is not the same as traditional banking education, the role of the animateur is different than that of the traditional teacher (Freire Institute, 2016). According to Smith (2009) animateur is the French word for the English word animator, defined as someone who breathes life into something and transforms it. In France, the word animateur refers to a number of functions: informal educator, community worker, and art workers, among others (Smith, 2009).

The essential job of the animateur in promoting engagement in students is achieved through a process called critical dialogue (Wallerstein & Auerbach, 2004). Beck and Purcell (2015) explain that the term critical dialogue can be misleading in that one may consider this term merely to mean serious conversation. Critical dialogue is in fact a groundbreaking form of communication that is produced by two transformed relationships: between teacher and
learner and between the learners and knowledge (Beck & Purcell, 2013). In order to promote critical dialogue, the animateur helps participants rethink how they can create opportunities for healing and growth. The animateur guides the participants in acquiring the tools to take the next steps in helping themselves and their communities (professional or civic) (Wallerstein & Auerbach, 2004).

Blackburn (2000) notes that critical dialogue is promoted by having the animateur become immersed in the reality of the student’s lives. The animateur becomes a catalyst to facilitate an educational process in which the oppressed themselves transform into creative subjects of the learning. Through immersion in the world of the student, the animator can create a space in which the oppressed educate themselves and each other (Blackburn, 2000). As noted by Beck and Purcell (2013), in order to be successful, the animateur must find innovative ways to enable people to re-see their lives and to re-examine their assumptions of what they have taken for granted. This is a very important component for problem-posing education, because oppressed people have been taught and conditioned to be passive and silent (Beck & Purcell, 2013). The animateur helps the students open up themselves to new experiences and a higher degree of self-realization, self-expression, and an awareness of belonging to a community that they can influence and change (Smith, 2009).

**Problem-Posing Education**

The educational approach proposed by Freire (1995) helps oppressed people challenge their own perception of the dominant group (oppressor) (Rugut & Osman, 2013). Since the oppressed think of themselves as “less than” the dominant group, this educational program includes engaging the learner in a process of disidentification with the dominant culture (oppressor) to help them imagine a new reality, and take action towards that new
Problem-posing education is a group process that relies on personal experience to produce social togetherness and mutual concern for change (Blackburn, 2000; Wallerstein & Auerbach, 2004). According to the Freire Institute (2016) there are several important concepts to understand when describing problem-posing education. The first concept is that there are two kinds of knowledge to be obtained from the group early in the process. The first is social knowledge, and the second is analytical knowledge. Both types of knowledge are crucial to problem-posing education.

Social knowledge refers to personal experience or knowledge from everyday life, and it usually comes from the person’s interactions in a community. It is historical, political, and social (Freire, 2016). The animateur elicits social knowledge from the group in a variety of ways, including story-telling, drawing, miming, and writing (Freire, 2016). The calling forth of social knowledge differs sharply from the traditional banking educational system in which the knowledge that people possess from their everyday lives is not accounted for in the learning process (Freire, 2016).

At times, social knowledge is not sufficient for tackling complex life situations that may come up during the education. Instead, analytical knowledge may be required to help the group work through issues uncovered in the sessions (Freire, 2016). Analytical knowledge may be accomplished through supplemental learning resources, either provided by the animateur or from an outside expert. Once equipped with awareness of their own knowledge and with the analytical knowledge they access through the animateur or other source, the group can pursue investigation of their living conditions. Such investigation by the group supplements what they began with and what was acquired with guidance by the
animateur (Freire, 2016).

Obtaining and synthesizing social and analytical education is important, but it is the application of analytical knowledge and social knowledge to a collective problem leading to concrete action that makes problem-posing transformative or life-changing. Through critical reflection on knowledge resulting in planned action, participants or students achieve transformative knowledge. They are transformed by the process of naming and initiating change. During the action-reflection cyclical process, participants pose questions rather than problem-solve, hence the name problem-posing education (Freire, 2016). The goal of problem-posing education is to inspire a continual cycle of reflection and action or praxis. Freire used the term action praxis to describe the process of reflecting on what worked or didn't work, and choosing subsequent actions based on critical dialogue (Freire, 2016).

Learning Stages

There are five learning stages that students need to be guided through in order to complete the action-reflection cyclical process. While guiding the participants through these stages of problem-posing education, the animateur presents the material to the students for consideration and prompts them to pose problems relating to themselves in the world. The first stage is known as understanding ourselves. In order to work together as a group, it is important to understand the values and principles from which the group works. The value focus can be determined by having members of the group tell one another about themselves. This can be accomplished by asking the group to record everyone’s family and background, education, work or role, involvements, sources of information, and views on society (Freire, 2016). It is important to take sufficient time for everyone in the group to write their histories.
Next, the participants take the basis for the group discussion, and codifies it into such things as pictures, story, among others (Rugut & Osman, 2013).

The second stage is called understanding what already exists (Freire, 2016). In this stage, the group decodifies the moral distress story from different viewpoints, considering the influences of rules, community, and the wider society at large. For example, in this dissertation, the event under study is moral distress, codified into moral distress stories. The groups pick one moral distress story and decodifies it, using three different foci (Freire, 2016). The first focus is values, ideas, beliefs, and culture; the second focus is power, rules, attitudes, and regulations; and the third focus is financial, procedural, professional, and managerial. This is the stage at which the problem posing starts because it is where participants begin to develop both awareness of their personal relationship to an issue and awareness of how the issue is experienced communally. When the understanding what already exists stage is complete, students will be better able to see how their experiences are not isolated but occur within societal structures. This prepares them for the next step: envisioning how they want to move toward the future.

Moving toward the future occurs in the third stage, called understanding where we wish to go. During this phase, the group is encouraged to think of their ideal concept for the community through achievable goals. They set a timeline for achieving their goals. Understanding where we want to go is based on the generative themes that were developed in the understanding what already exists phase. It is important also to begin to develop the accompanying ideal societal structures that will be needed for the ideal notion of the community to exist. Once the ideal vision is completed, the next step is to devise a way to put ideal concept into action or practice (praxis) (Freire, 2016).
In the fourth stage, called strategy building, planning, resource-acquisition, and implementation, members of the group determine what, why, when, where, and how to move the practice or action forward. Issues to consider during this stage are who are the allies and antagonists of the ideal concept, and what skills, tools, plans, trainings, and evaluations are needed to bring it into being. Action-reflection, sometimes described as the fifth stage, is also a process that permeates the whole program of the problem-posing education (Freire, 2016). Action-reflection refers to the continual interaction of action (praxis) and reflection to determine what worked and what did not work. Action-reflection affects any subsequent changes in the action, and this is based on critical dialogue, which is the form of communication between teacher and learner and between the learners and knowledge (Beck & Purcell, 2013; Freire, 2016).

**Conscientization**

*Conscientização* is a Portuguese word (conscientization is the English translation) used by Freire (1995) to describe the process of “learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality” (p. 17). Conscientization names both a process in Freirean terms and also a moral imperative. The source of the moral imperative lies in Freire’s belief in the equal dignity of all human beings, including the right to be treated with absolute dignity and respect, the right to knowledge and culture, the right to criticize one’s situation, and the right to act to change it. Freire was convinced that simply becoming aware of one’s social injustice and oppression was not enough but that one needed to act upon it. By definition, Freire’s (1995) conscientization names a moral process that arises out of a belief in human equality and dignity and encompasses cultivating awareness about and acting to change the conditions of
social injustice that lead to inequity.

It is important to remember, as Hinchey (2010) points out, that working towards conscientization is a continual process in which one learns and relearns about oneself and one’s relationship to the world. Montero (2007) claims that conscientization is an emotional journey where one recognizes the impact of choices and conditions that have influenced one’s living conditions. There may be moments of understanding and clarity during this process, but as Beck and Purcell (2013) explain, the journey can also be an emotional one that leaves people feeling angry about having endured a situation for so long. Ideally, through conscientization, people who are oppressed come to understand that they can change their reality, so the rewards are potentially great as well (Freire, 1995).

**Summary**

In this chapter, I reviewed the literature on moral distress and followed with an explication of the theoretical framework that I use in the dissertation. The literature review demonstrated that moral distress in nursing has its conceptual origins in ethics and that nurses are moral agents inspired by ethical motivations to act in their patients’ best interests (Storch et al., 2002). Nurses suffer from moral distress when they are held back from acting as moral agents for their patients (Jameton, 1984). Since 1984, the conceptualization of moral distress has evolved to include consideration of the role of hierarchical systems and power dynamics in creating and perpetuating moral distress in nurses (Varcoe et al., 2012b). It is well-established in the literature that moral distress is a significant problem for nursing (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015; Piers et al, 2014).

In the second part of the chapter, I provided an overview of the theoretical influences for the dissertation. I first considered power as conceptualized by Michel Foucault, not as a
quality of an institution but a product of the relationships in it (Foucault, 1977; Sadan, 1997/2004). Next, Keltner’s et al. (2003) discussion provided the motivation for those seeking power in that power provided those with it safety and control contributed to their importance. Relevant to this is Johnson’s (2005) belief that those with power are dominant, and they continue to benefit from cultural and structural advantages that developed over time (Johnson, 2005). Ann Cudd’s (2006) concept of social oppression was outlined to explain how episodes in nursing’s historical and cultural background have resulted in its status as socially oppressed.

I presented a framework developed by Iris Young (1990) to clarify oppression in nursing as defined by exploitation, marginalization, powerlessness, cultural imperialism, and violence. The problem of the awareness of nurses of their status as an oppressed group was introduced, and I reviewed research showing that nurses suffer from a variety of OGB that include silencing and low self-esteem, assimilation and self-doubt, marginalization, and bullying and lateral violence. I concluded the section with consideration of how the concepts of moral distress, power, and oppression are linked.

Finally, I introduced Paulo Freire’s (1995) Pedagogy of the Oppressed as the theoretical framework underpinning the moral distress intervention that I developed and piloted in this study. Freire’s philosophy of oppression was described, followed by a detailed discussion of his pedagogy, including discussion of the animateur role, problem-posing education, and the learning stages specific to problem-posing education. I concluded with a description of Freire’s (1995) conscientization, which names a process that allows for the belief in human equality and dignity and encompasses cultivating awareness about and acting to change the conditions of social injustice that lead to inequity.
CHAPTER 3

METHODS

The purpose of this study was to develop and pilot test an intervention with critical care nurses who have recently experienced moral distress. The intervention pilot answered the following research questions: “What is the impact of a conscientization intervention on nurses’ perceived sense of empowerment and their responses to clinical situations that create moral distress?” and “What is the feasibility and acceptability of this intervention?”

**Development of the Intervention**

The intervention was modeled on Freire’s problem-posing framework and pedagogy for identifying oppressive factors and promoting empowerment (Freire, 1995). The construction of the intervention was completed in consultation with an international expert in Freirean pedagogy to ensure that the process was reflective of the development of conscientization and that it followed the steps in the problem-posing method. As a result, a three-session intervention was developed and named after the following three phases of Freire’s pedagogy: Critical Reflection, Critical Motivation and Critical Action (Freire, 1995; Ridner, 2004).

In the following sections I provide (a) an explanation of problem-posing education, (b) a description of the Spiral Model, (c) syllabi detailing the three-session goals, (d) strategies, (e) tools, (f) activities, and (g) homework based on the phases and learning stages of problem-posing education. Specific tools used to help the animateur guide participants through the Freirean pedagogy progression were a critical component of this intervention. These tools are detailed in the educational plan, and copies are available in the appendices.
The role of the animateur as well as the activities surrounding that role are also highlighted in the plan.

After the initial intervention sessions were developed by the researcher with input from Dr. John Lockhart, Director of the Freirean Institute from University of Central Lancashire in the United Kingdom, they were tested in training sessions. These training sessions took place in 2017 on March 12, 13, and 15 at the University of Missouri-Kansas City (UMKC). The volunteers that participated in this training were seven UMKC nursing students (one graduate and six pre-licensure). Dr. Lockhart was in attendance and acted as co-animateur, expert coach, and evaluator. The purpose of the training sessions was to ensure that the sessions were consistent with the Freirean method, to practice the intervention before the study intervention took place, learn the components of the animateur role, become familiar with the tools, and test for time management. After these training sessions were completed, the program was evaluated with Dr. Lockhart. Based on these evaluations, modifications to the intervention sessions were made, resulting in the final interventional sessions as detailed in this paper.

**Four Stage Model for Problem-Posing**

The Spiral Model from Arnold (see Figure 1) was the four-stage process that I aligned with the Freirean approach to help drive the flow of this problem-posing intervention through a continual cycle of reflection and action. For the purposes of this study, an additional phase called “Envisioning” was added between stage three and four. The corresponding alignment is displayed in the title line of the detailed sessions documented in this chapter. Session One: Critical Reflection was aligned with the “Experience of Participants” and “Look for Patterns” in the Spiral Model from Arnold, Session Two:
Critical Motivation was aligned with “Add New Information and Theory” and “Envisioning.” Session Three: Critical Action was aligned with “Practice Skills, Strategize and Plan for Action” and “Apply in Action” (Arnold, Burke, James, Martin, & Thomas, 1991).

**Figure 1.** The spiral model


**Conscientization Educational Sessions**

The intervention was composed of three consecutive sessions, each named after the three phases of Freire’s pedagogy: Critical Reflection, Critical Motivation and Critical Action (Freire, 1995; Ridner, 2004; Watts, Diemer, & Voight, 2011). These three sessions were also intertwined with the five learning stages of problem-posing education (a) understanding ourselves, (b) understanding what already exists, (c) understanding where we
wish to go, (d) strategy building…, and (e) action reflection. The goals for the conscientization intervention were to recognize that moral distress evolves from a lack of power due to oppression within the hospital hierarchy, develop the agency to encourage change, and engage in behaviors that draw attention to the difference in power and promote change (Diemer, McWhirter, Ozer & Rapa, 2015).

Session One: Critical Reflection

Each participant was provided with a folder containing the paperwork, consents, and tools that they needed for the entirety of the three-session intervention. As detailed in the syllabus Session One: Critical Reflection began with an explanation of the study, followed by the signing of consent forms and then completion of four instruments: the demographic questionnaire, the moral distress scale–revised (MDS-R), the psychological empowerment scale (PES), and the conditions of work effectiveness Questionnaire-II (CWEQ-II). Once these were completed, the animateur guided the participants to the learning stage called “Understanding Ourselves” and worked with the tool of the same name (see Appendix A). The participants were asked to complete this tool as a group, so the members got to know each other and gain an understanding of their everyday lives. Once the understanding ourselves tool was complete, each participant was instructed to “Write down your story that caused you to experience moral distress,” completing the step known as codifying the generative theme of moral distress by sharing their personal stories. Next, each participant placed their handwritten stories on a table and all members were given 15 minutes to read each other’s stories. Once done, the participants were instructed to reconvene into their small groups and picked one of the moral distress stories for further analysis.

In the next phase called “Understanding What Already Exists” the animateur guided
participants in decodifying the stories using the tool of the same name (see Appendix B). The purpose of this was to have the participants evaluate their moral distress story from three different foci and determine what influenced these foci had on the event (Freire, 2016). The three foci were (a) culture, which includes values, ideas, beliefs, faith, ideology, prejudices, opinions, and attitudes; (b) power, which includes rules, regulations, decisions, procedures, and systems; and (c) resources, which includes finance, staffing, and expertise. By evaluating the moral distress stories through the three foci, the group members discussed their obstacles, their support systems, and what they could have done to make changes through the lens of the three foci (Freire, 2016).

Next, the participants were encouraged to work through the Weighing Options tool where they were asked to evaluate the moral distress situation by evaluating what made the situation better or worse (see Appendix C). The purpose of this was to have the participants consider options that could be applied in the future. At the end of the session, each small group presented their results to the entire group, with reference to the moral distress stories and the two completed learning stages of “Understanding What Already Exists” and “Weighing Options.” The first session ended with a homework assignment, wherein each participant was required to read Matheson and Bobay’s (2007) article, “Validation of oppressed group behaviors in nursing,” and answer the discussion questions. This article introduced the concept of oppression/emancipatory theory, the culture of silence that exists in nursing, and argued that liberation cannot occur without awareness.

The goal of Session One: Critical Reflection was to have the participants talk about themselves, codify the theme of moral distress through their moral distress stories and identify and decodify their stories into the foci of understanding what already exists (Freire,
Critical reflection is described as the recognition of social inequalities along with an understanding of the unjust applications of sociopolitical power that create them (Hipolito-Delgado & Lee, 2007). A schematic for Session One is in Appendix D). The syllabus for Session One is depicted in Figure 2.

### Session One: Critical Reflection Phase (4 hours) Learning Stage of Understanding Ourselves and Understanding What Already Exists

Corresponds with “Experience of Participants” and “Look for Patterns” in the Spiral Model from Arnold (Arnold et al. 1991).

**Study explained, consent obtained**

Pre-intervention tools= MDS-R, PES, CWEQ-II, and Demographic Survey

**Entire group (20-30 minutes)**

**II. Session goals for participants**

A. Reproduce personal stories and background to elicit thinking about values, motivations, and vision for society (see tool Understanding Ourselves).

B. Codify the generative themes of moral distress into the moral distress stories.

C. Decodify the moral distress stories into elements of awareness of culture, power, and resources (see tool Understanding what Already Exists) (60 minutes) reflecting on how elements fit into a variety of options. Continue to decodify by weighing options (see tool Weighing Option).

D. Describe relationships between feelings of moral distress and power dynamics.

E. Comprehend the immanent (hidden) logic within a context and confront the model of power internalized.

**III. Activities or Strategies for Animateur**

A. Assist participants in completing Understanding Ourselves tool.

B. Encourage participants in sharing moral distress stories (60 minutes).

C. Aid participants in using the findings from each category to draw relationships between the categories.

D. Support individual group moral distress story presentations to large group.

**IV. Homework (analytical knowledge homework assignment):** Matheson and Bobay’s (2007) “Validation of oppressed group behaviors in nursing.”

**V. Homework Goal:** Provide the participants with information about oppression, suffering in silence, and power in nursing to introduce them to the concept of considering the impact that this information had on their moral distress experience.

*Figure 2. Syllabus for Session One*
Session Two: Critical Motivation

As outlined in the syllabus for Session Two: Critical Motivation began with a large group discussion about the questions from the homework assignment. The questionnaire was designed to help participants learn about the role of power and oppression in nursing. Questions from the questionnaire asked if the article changed the student’s understanding of oppression in nursing and if they learned anything from the article that can help explain their moral distress story. The purpose of this exercise was to give the group some analytical knowledge about oppression and emancipation before moving to the next step called “Understanding Where We Wish to Go” where the animateur guided the group in completing the tool of the same name (see Appendix E). The purpose of this tool was to help the participants decodify and envision future work situating where they can apply changes through their newly found understanding acquired from the first session. Again, the tool asked the participants to consider the three foci of culture, power, and resources (Freire, 2016). In addition to applying what was learned in the first session, as alluded to by Cammarota (2011), who wrote on social justice pedagogy and incorporated the Freirean method in his work, the participants gained inspiration from each other by working as a group. Each group was once again instructed to present their findings to the large group, and the session concluded with a homework assignment that requires each participant to read Fletcher’s (2006) article titled, “Beyond dualism: Leading out of oppression” and answered the discussion questions. This article introduced the importance of the development of self-awareness through reflection, which helps break the cycle of oppression and leads to changes in the structures that oppress nurses.

According to Hipolito-Delgado and Lee (2007), who cited Freirean methods in his
work on oppression and empowerment theory for school counselors, the goal of Session Two: Critical Motivation was to guide the participants collectively to identify, motivate, and redefine their social identity and reclaim power, then to incorporate that perceived ability to push for change in social and political conditions. A schematic for Session Two is in Appendix F. The syllabus for Session Two is depicted in Figure 3.

<table>
<thead>
<tr>
<th>Session Two: Critical Motivation Phase (3 hours) Learning Stage of Understanding Where We Wish to Go corresponds with “Add New Information and Theory” and “Envisioning” added on the Spiral Model from Arnold (Arnold et al., 1991).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Session Goals for Participants</strong></td>
</tr>
<tr>
<td>A. Continue to decodify the moral distress stories into values, concepts and hopes for the future.</td>
</tr>
<tr>
<td>B. Evaluate the moral distress stories of the group and gather the information from the group.</td>
</tr>
<tr>
<td>C. Identify aspects of powerless situations within the moral distress stories until they recognize themselves in the situation.</td>
</tr>
<tr>
<td><strong>II. Activities or Strategy for Animateur</strong></td>
</tr>
<tr>
<td>A. Guide large group discussion based on summary of the critical reflection from Session One and ideas generated from the Matheson and Bobay article. (45- 60 minutes) (See Session Two Matheson and Bobay article questions.)</td>
</tr>
<tr>
<td>B. Motivate the participants to identify ideas, values, concepts, and hopes that characterize the moral distress story and obstacles that impede people’s fulfillment.</td>
</tr>
<tr>
<td>C. and large group discussion to identify concrete representation of the bureaucratic themes and power. (60 minutes) (See tool Where We Wish to Go).</td>
</tr>
<tr>
<td>D. Assist participants in decodifying aspects of the situation and reflect critically on them.</td>
</tr>
<tr>
<td>E. Support the group in self-identifying aspects of the situation.</td>
</tr>
<tr>
<td><strong>III. Homework (analytical knowledge homework assignment):</strong> Fletcher (2006), article “Beyond dualism: Leading out of oppression”.</td>
</tr>
<tr>
<td><strong>IV. Homework Goal:</strong> Provide the participants with information on oppression and power in nursing and introduce them to the concept of change and guiding out of oppression.</td>
</tr>
</tbody>
</table>

*Figure 3. Syllabus for Session Two*
Session Three: Critical Action

As detailed in the syllabus for Session Three: Critical Action began with a review of the Fletcher (2006) article “Beyond dualism: Leading out of oppression” within the large group. Questions asked if they thought the article helped them examine how they might change the way they thought about themselves and if they thought self-awareness was necessary for change. The purpose of this exercise was to present analytical knowledge with regard to developing self-awareness through reflection and use this self-awareness as a strategy for breaking the cycle of oppression and initiating changes in the structures that oppress nurses (Fletcher, 2006). After this discussion, the small groups participated in an exercise called “Strategy Building, Planning, Resource-Acquisition, Implementation” using the tool of the same name (see Appendix G). In this activity, the animateur guided the participants to consider the components of individuals, organizations, institutions and the government that are impacting their world and work and to examine how they influence moral distress situations.

The final component of Session Three: Critical Action consisted of creating an action project with guidance from the animateur using the Action Project Template tool (see Appendix H). The goal of the third intervention session was for participants to learn from other participants about how they worked through their emancipatory processes. Critical action refers to an individual or group endeavor taken by nurses to address oppression, empowerment, and moral distress. Sometimes, these endeavors are personal change projects; other times, critical actions require an assessment of the institutions in the nurses’ lives and joint efforts to work for change within these institutions. Critical action acknowledges that the causes and/or consequences of some clinical problems reflect political, economic, and
psychological oppression, and that these experiences of oppression require public and institutional solutions. The action project was presented by the small group to the large group for discussion and reflection, and participants were encouraged to make this presentation as creative as possible (Prilleltensky, 1997). A schematic for Session Three appears in Appendix I. The syllabus for Session Three is depicted in Figure 4. At the conclusion of the third session, the quantitative tools were re-administered.

| Session Three: Critical Action Phase (3 hours) Stage of Building and Testing Strategies, Acquiring Resources and Implementing Action.  
Corresponds with “Practice Skills, Strategize and Plan for Action” and “Apply in Action” on the Spiral Model from Arnold (Arnold et al., 1991). |
|---|
| **I. Session Goals for Participants**  
A. Appraise how nurses think about themselves and identify new possibilities for leading in nursing by reading the Beyond Dualism article.  
B. Describes potential action project.  
C. Interpret the experience of how action can affectively interact to transform their reality.  
D. Apply the self-confidence to engage in change within themselves and as Members of their communities (nursing communities).  
E. Interpret how self-awareness through reflection can begin to break the cycle of oppression.  
F. Relate how change can happen from developing skills such as planning, negotiating, thinking critically, writing, presenting to groups, developing campaigns, and having visions for better conditions (Wallerstein & Auerbach, 2004). (Analytical knowledge). |

| **II. Activities or Strategy for Animateur**  
A. Encourage group discussion (45-60 minutes) (See Session Three Fletcher Article questions for group).  
B. Stimulate the group and encourage reflection and peer teaching actions.  
C. Support the group to understand that action means learning to see themselves as social beings with rights to just and fair treatment within institutions and their workplaces.  
D. Inspire people to choose the actions that seem achievable and are appropriate within their work and community context (120 minutes). (See tool: Strategy Building Planning Resources). (60 minutes). (Action Project Template).  
E. Motivate increased awareness in small steps and provide follow-up with |
A transformative parallel database convergent mixed methods pre- and post-intervention test design was used to pilot the conscientization intervention and evaluate the intervention for feasibility, acceptability, and initial outcomes. Parallel database convergence is the simultaneous and independent design, collection, and analysis of both qualitative and quantitative data, followed by a merging of results from the two data sets to evaluate them for similarities (convergence) and differences (divergence) (Creswell & Plano Clark, 2011). A similar parallel database design was used by Finlay and Kobayashi (2018) in a social science study evaluating social isolation in older adults in the United States. In-depth individual interviews and logistic regression models were conducted and analyzed separately. Merging of the data helped the researchers identify certain categories of quantitative factors followed by individual experiences with social isolation and loneliness (Finlay & Kobayashi, 2018).

The strength of using this type of design is that both sets of results can validate each other and provide stronger evidence that promote insights that may otherwise be missed (Creswell & Plano Clark, 2011a). The challenges are that it requires that the researcher to have training or familiarity with both qualitative and quantitative research methods and is generally more time consuming compared to one method (Creswell & Plano Clark 2011a). Using the convergent analytical approach I analyzed (a) qualitative data from narrative methods, output from group work within the problem-posing conscientization intervention,
and post intervention individual interviews, and (b) quantitative data from a demographic questionnaire, data related to recruitment and dropout rates, quantitative measurement of moral distress, psychological and structural empowerment in work settings, and correlational data between number of sessions attended and outcomes. The convergence of qualitative data with quantitative data provided triangulation to determine if the intervention was feasible and acceptable and if the intervention helped to increase perceptions of personal and group empowerment, as well as psychological and structural empowerment in the workplace.

The design has a transformative purpose, in that it was guided by a perspective focused on change (Creswell & Plano Clark, 2011b) to help raise awareness and empower action in marginalized groups (Sweetman, Banidee & Creswell, 2010). This type of research focuses on addressing power imbalances in society and is consistent with principles of conscientization developed by Paulo Freire (1995) in *Pedagogy of the Oppressed*.

**Qualitative Measures**

To evaluate initial outcomes of the conscientization intervention, data was obtained from three sources. The first source was the nurses’ narrative stories of moral distress experiences which were written by the participants themselves and shared in the first of three sessions of the intervention. Narrative analysis of the stories provided information about the groups’ sources of moral distress, behavioral responses of the participants, and the impact of oppressive power dynamics as causes of moral distress. The second source was the recorded discussions and written output from the work the participants completed in each of the three group sessions. The third source was the post-intervention individual
interviews which I used to evaluate the feasibility and acceptability of the intervention as well as information related to perceived outcomes.

**Quantitative Measures**

A demographic data collection tool was used to collect data to describe the population as well as data related to recruitment strategies and attrition (see Appendix J). Three instruments were used to assess the quantitative levels of moral distress, psychological empowerment and structural empowerment in work settings. These three instruments are described below.

The moral distress scale–revised (MDS-R) measured the intensity and frequency of moral distress (see Appendix K). This 21-item Likert ordinal data scale is an abbreviated form of Corley’s (2001) original MDS with possible response options from 0-16. The scale includes a frequency range from 0 (never) to 4 (very frequently) and an intensity range from 0 (none) to 4 (great extent) (Hamric et al., 2012). The mean moral distress scores were calculated for each item by multiplying frequency by intensity (f x i), with a score ranging from 0 to 16. Less distressing items had lower (f x i) scores, and more distressing items had higher (f x i) scores. The total moral distress score was obtained by summing each item’s (f x i) score, which resulted in a range of 0 to 336. Lower composite scores have lower moral distress, and higher overall scores have higher moral distress (Hamric et al., 2012). Moral distress frequency and intensity are also calculated separately. The range for moral distress frequency scores is 0 to 84 for both frequency and intensity.

The range of scores for total MDS-R was broken into quartiles for total moral distress level ranges. They were as follows: 0-83 (none-slight), 84-167 (medium), 168-252 (moderate) and 253- 336 (severe). This quartile scale was created by the researcher to equate...
the total product scores multiplied by the 21 questions on the moral distress scale for a scale ranging from 0 to 336. The range of scores for both frequency and intensity were broken into three sections for level ranges 0-27 (low), 28-56 (medium), and 57-84 (high). This scale was also created by the author to equate the total product score multiplied by 21 questions for the frequency and level, each ranging from 0-84. Interrater agreement scores for the scale items are high at 88% (Hamric et al., 2012). Internal consistency was established by Hamric et al., (2012) using Cronbach for nurses (.89) and for all participants (.88). Construct validity was established through comparison with Olson’s Hospital Ethical Climate Survey, where moral distress and ethical climate were found to be negatively correlated ($r = -.40, p < .001$) (Hamric et al., 2012). Permission to use the scale was obtained (see Appendix L).

The psychological empowerment scale (PES) measured the perceived level of psychological empowerment (see Appendix M). The 12-item scale had Likert response options in the form of letters A-G for four sub-dimensions: meaning, competence, self-determination, and impact. Numbers were assigned to coincide with the letter options so that quantitative analysis could be done. For example, the scale was the following: (A)1= very strongly disagree, (B)2= strongly disagree, (C)3= disagree, (D)4= neutral, (E)5= agree, (F) 6= strongly agree, (H)7= very strongly agree. The four subscales were summed for a total empowerment score with possible range of 12-84, with higher scores representing higher psychological empowerment. The test retest-reliability was strong, and validity estimates for the dimensions had Cronbach’s alpha scores between 0.81 and 0.89 (Spreitzer, 1995; Spreitzer & Quinn, 2001). In the present study, I calculated scores into the following levels: 12-36, (low), 36-60, (medium), and 60-84 (high). I calculated composite scores for the
frequency and level, each ranging from 12-84. Permission to use this tool was obtained (see Appendix N).

The conditions of work effectiveness questionnaire-II (CWEQ-II) was used to measure the perceived level of structural empowerment in the workplace, in other words, how the participants viewed their access to those in power (see Appendix O). Composed of 19 items with Likert response options from 1 to 5, the scale had six subscales: (a) opportunity, (b) information, (c) support, (d) resources, (e) formal power, and (f) informal power (Laschinger, Finegan, Shamian, & Wilk, 2001). Opportunity (three items) refers to access to opportunities for growth and movement in the organization and opportunity to increase knowledge and skills. Information (three items) refers to having access to information on organizational goals and policy changes. Support (three items) relates to the ability of the worker to take risks and their perceived autonomy in making decisions. The component of resources involves having the ability to mobilize resources needed to get the job done. Access to these empowerment structures is facilitated by (a) formal power characteristics (three items) such as flexibility, adaptability, and creativity associated with discretionary decision-making, visibility, and centrality to organizational purposes and goals and (b) informal power characteristics (four items) derived from social connections and the development of communication and information channels with sponsors, peers, subordinates, and cross-functional groups (Laschinger et al., 2001). Permission to use this scale was obtained (See Appendix P).

Items on each of the six subscales are averaged to provide a score for each subscale ranging from 1 to 5. These subscale scores are then summed to create a total empowerment score (range 6–30). All items are summed for possible total scores of 19-95, with higher
scores representing a greater sense of empowerment. Higher scores represent higher perceptions of empowerment (Laschinger et al., 2001). The range of scores were divided by three for three level ranges. They are 0-33, (low), 34-62, (medium), and 63-95 (high). This scale was created by me to equate the total product score for the frequency and level.

Good construct validity for the CWEQ-II Tool was demonstrated (Laschinger et al., 2001). Construct validity was reported to be high by the authors as determined by confirmatory factor analysis and by high correlation between the total score and the global empowerment score (Faulkner & Laschinger 2008, Laschinger et al., 2001).

**Recruitment Strategies**

Participants were recruited through ads posted on the Greater Cincinnati Chapter of American Association of Critical Care Nurses (AACN-GCC) website, Facebook, and Twitter accounts (see Appendix Q). This method was used because there are approximately 200 members of the chapter, including 167 Facebook followers and 52 Twitter followers. The recruitment letters posted on the website included the researcher’s name and contact information (email and phone number) with instructions for the interested participants to contact the researcher within a two-week period. Permission for both online and in-person recruiting was obtained from AACN–GCC. Permission to use the AACN website was obtained (see Appendix R).

The call for the study was posted on the AACN website, Facebook, and Twitter on August 1, 2017. Within the first week, 10 candidates contacted the researcher. Over the next two weeks, communication and discussion with these 10 candidates resulted in four agreeing to participate in the study, and six declining. By the end of August 2017, six more candidates contacted the researcher. Out of these six additional candidates, three agreed to
participate in the study, and three declined. A total of seven nurses were enrolled by the end of the first month.

Participant recruitment continued during the month of September 2017, when five additional candidates were recruited through snowball sampling, meaning existing research subjects helped recruit participants for the research through people they knew (Noy, 2008). Twelve participants were enrolled in the study by the end of September 2017. A thirteenth participant, who had previously declined to participate, requested to be in the study shortly before the study started and was enrolled. Reasons given for declining to participate included not being able to take time off from work, too much time investment, or other commitments. No one refused participation in the study due to lack of interest in the intervention or lack of understanding the purpose of the study or topic, and no participants were lost in the study.

Sample

The sample consisted of 13 critical care nurses from the greater Cincinnati area. A purposive sampling strategy was used to select participants. The purposive approach to sampling differs from random sampling in that it seeks to enroll individuals who had a specific experience of or perspective on the phenomenon being studied (Robinson, 2014). The sample size of 13 was deemed appropriate for a pilot feasibility study since the smaller number was thought more likely to produce in-depth data to understand the complex experiences of moral distress, oppression, and empowerment, and sufficient for determining feasibility and acceptability. The rationale for choosing critical care nurses was their frequent exposure to complex patient care situations, which often involve what can be
perceived as futile care or the inappropriate causing and prolonging of patient suffering (Browning, 2013).

The inclusion criteria were registered nurses who had at least one year of critical care experience and a recent (within the previous 12 months) experience of moral distress. To determine if nurses had experienced moral distress, the recruiting letter included a definition of moral distress along with a description of feelings and behaviors commonly associated with moral distress in research. Potential participants were asked to self-identify if they have experienced moral distress based on that information.

Setting

The three-session educational intervention took place in a private conference room at a corporate and fitness center affiliated with a local health care corporation. Permission to use the conference room at this facility was obtained (see Appendix S). The location was roomy, quiet, comfortable, and private. It was also conveniently located for nurses in the membership of the AACN-GCC. Food and beverages were provided at each session by the researcher. The post-intervention interviews were conducted and recorded in the café at the same corporate and fitness center affiliated with a local health care corporation. Even though it was a café, the interviews took place in a private and secluded part of the café with only the interviewee and researcher present.

Institutional Review Board

The Institutional Review Board (IRB) at the University of Missouri-Kansas City granted approval on July 10, 2017 (see Appendix T). Written informed consent was obtained from all 13 participants prior to intervention and data collection. Each participant was assigned a code letter (A, B, C…) that was used during all phases of the study, including the
sessions and the post-intervention interviews. No names appeared on any data collection forms, and the survey data was reported in an aggregate format, to prevent any individual identification of participants could be done.

Audiotaping of the three educational sessions, as well as the post-intervention interviews was necessary to capture the conversations and to accurately interpret the data. The participants consented to the audiotaping as part of the informed consent, which was reviewed by participants before signing. The professional transcription service that transcribed all of the audiotapes, provided a signed confidentiality agreement. During the study, de-identified written work and audiotapes remained in my possession. After the study, all consents, data, and written materials will be transferred to the School of Nursing and Health Studies at the University of Missouri-Kansas City to be stored in REDCap at UMKC. The participants were paid $100.00 upon completion of the sessions and the post-intervention interviews. This payment is commensurate with the significant amount of time required to participate in the study, including 12 hours of intervention, one hour of post intervention interviews, travel time, and rearrangement of work schedules.

**Protection of Human Subjects**

As mentioned above, this study met all the requirements for the protection of human subjects and was approved by the Institutional Review Board (IRB) at the University of Missouri-Kansas City. As part of the IRB requirements, I identified benefits that participants might obtain from participating in the study. Those benefits included being able to talk about their moral distress experiences, evaluate these experiences through a new perspective, and learn the steps to empower themselves and potentially prevent moral distress from happening in the future. Additionally, the nurses were potentially able to recognize moral
distress in other nurses and help them as well, thus benefiting the profession of nursing as whole.

As mentioned previously, measures were taken to prevent harm to participants, and all participants were fully aware that at any time they could withdraw from the study. In addition, because the intervention had potential to raise uncomfortable feelings for the participants, the researcher provided the participants with names of local psychologists in the event they felt they needed further assistance. All provisions were made to maintain informed consent and confidentiality for all subjects.

**Procedures**

In the following section, the procedures that made up the three-session intervention entitled Critical Reflection, Critical Motivation, and Critical Reflection, will be discussed in detail. This will be followed by a description of the methods used in post-intervention individual interviews.

**Three-Session Educational Intervention**

Two weeks prior to the first session on October 10, 2017, reminder emails were sent to the entire group with the time, dates, and directions to the fitness center. The day before the first session, all 13 participants were once again sent reminders by text, with descriptions of the session and instructions to dress comfortably. In preparation for the intervention, individual folders were assembled and labeled with each participant’s code letter. These folders contained a consent form, three pre-intervention quantitative tools, copies of the exercises to be performed during the interventions, two articles for the homework assignments, three post-intervention quantitative tools, and paper on which to write the moral distress stories.
The three groups were created by assigning participant Code A to Group 1, participant Code B to Group 2, and participant Code C to Group 3, and so on. Once completed, Group 1 had five members assigned, Group 2 had four members assigned, and Group 3 had four members assigned. A master’s prepared nurse colleague assisted during all three of the intervention sessions. The assistant was recruited to help maintain the flow of the program, set up the room, answer questions for small group work, gather tools, and assist the primary investigator as needed. Before the first intervention occurred, the assistant was briefed on the step-by-step outline of the program and the overall problem-posing method.

On October 10, 2017, the date of Session One, the researcher received text messages from six participants at 7:00 a.m. stating they were not able to attend that day. All were apologetic and expressed a desire to continue in the intervention. Seven of 13 participants came to the first session, and the researcher decided to reorganize the flow of the first and second sessions to accommodate the missing participants. The seven participants who attended understood the plan and all agreed to proceed according to the altered schedule. All three groups had at least two people in attendance during the first session, so the researcher was able to initiate the group work central to the Freirean process.

At the beginning of Session One, study goals and procedures were reviewed, and written consent was obtained. Next, the participants completed the demographic tool and the three quantitative measures (MDS-R, PES, CWEQ-II). Session One proceeded as described in the syllabus, with one change made to the intervention based on a participant’s suggestion. A participant suggested that, rather than posting the stories on the wall for all to read, they could each read their moral distress stories out loud for the entire group to hear. This change resulted in a much more meaningful and heartfelt rendering of the stories, and everyone in
the room was able to hear the stories at the same time. Session One continued as planned in the syllabus. At the end of Session One, those who were present were reminded that some of Session One would be repeated at the beginning of Session Two, and that the researcher would be enlisting their help in getting some of the new participants up to speed. They understood and were very willing to help. Session One ended with the assignment of homework. The audiotaped sessions from Session One were sent to the professional transcription service several days after the sessions occurred.

Session Two took place on October 17, 2017. As anticipated, more participants attended this session, with 11 out of the 13 participants attending. Two of the Session One participants did not make the second session; five from the first session returned. As the new participants arrived, they were seated in their assigned groups. The revised plan was to have the six new participants catch up to the Session One members. To start the intervention, the six new participants consented and then completed the demographic and three quantitative tools. Next, a brief overview of what had happened in Session One was provided. Because it was crucial to the intervention for the nurses to write and share their moral distress stories, the six new participants were asked to write and read their moral distress stories. Several other participants repeated their moral distress stories from Session One, so the new attendees could experience the impact of sharing moral distress stories with the group.

Originally, the homework assignment discussion would have been the first part of the second session, but this was changed to after all the participants had a chance to write and read their stories. There were five people at Session Two who had also attended Session One, and they had done the homework assignment on oppression in nursing. They were asked to take the lead in the discussion to promote group interaction. Finally, the groups
were asked to review the previous week’s homework “Understanding What Already Exists and Weighing Options.” This enabled the six new participants to understand the discussion that occurred the previous week and prepared all to complete the rest of Session Two. As in Session One, Session Two also ended with a homework assignment. The audiotapes from Session Two were sent to the professional transcription service several days after the sessions occurred.

Session Three took place on October 24, 2017, with all 13 participants in attendance. Since there were two members from Session One who did not attend Session Two, the researcher quickly reviewed the sessions to date. The review of the Session Two homework assignment took place at the beginning of Session Three, and since most of the participants had attended Session Two, this worked according to plan. The small group work continued, and Session Three was completed as described in the syllabus. Audiotapes from Session Three were sent to the professional transcription service.

**Post-intervention Interviews**

After the intervention, a one-week rest and reflection period were given to both the participants and the researcher. During that week, each of the 13 participants were contacted to arrange a time and date for the post-intervention interviews. All 13 interviews were scheduled for November 6-13, 2017, and all 13 individual interviews were completed during that week. The interviews took place in the café of the corporate and fitness center affiliated with a local health care corporation, as this was convenient for the participants and allowed for privacy during the interview. All 13 individual post-intervention interviews were conducted with only the participant and researcher in attendance in a quiet and private area of the café, and all 13 interviews were audiotaped.
The purpose of the post-intervention individual interviews was to evaluate two items from aim 2 – the feasibility and acceptability of the intervention, and from aim 3 – perceived outcomes of the intervention. To ensure that the interview questions were evaluating feasibility, three criteria as suggested by Bowen et al., (2009) were incorporated into the questions. These three criteria were: acceptability, practicality, and implementation. As per Bowen et al. (2009), acceptability is an evaluation of how the intended individual recipients react to the intervention; practicality explores the extent to which an intervention can be delivered with available resources, time, and commitment; and implementation concerns the extent, likelihood, and way an intervention can be fully implemented as planned and proposed (Bowen et al. 2009). Some examples of these questions were the participants’ satisfaction with the length of the program, their view of the flow of information, and their view of the degree to which the intervention provided a safe space (see Appendix U).

To evaluate the perceived outcomes of the intervention, interview questions were targeted at the participants’ perceptions of their ability to recognize that moral distress evolves from a lack of power due to oppression in the hospital hierarchy, to have them develop the agency to encourage change, and to engage in behaviors which help draw attention to the difference in power and promote change. Some examples of these questions include: (a) did your understanding of moral distress change after the intervention, (b) do you believe the intervention will help you with morally distressing situations in the future, and (c) did power and perceived power exist in your work organization (see Appendix V). All 13 de-identified audiotapes of the individual interviews were sent to the transcriptionist at one time.

Total Mixed Methods Data Analysis
The study included the following three specific aims: aim 1 was to develop a critical consciousness empowerment intervention as described previously; aim 2 was to evaluate feasibility and acceptability of the intervention. Data relevant to aim 2 were collected from demographic data, recruitment and attrition information, and individual post-intervention interviews. Aim 3 of the study was to evaluate the effects of the conscientization intervention on nurses’ sense of empowerment. Data relevant to aim 3 were both qualitative and quantitative and were collected from output from each of the three-group sessions, which included standardized quantitative instruments, written texts, and transcribed audio recordings of group led discussions, as well as transcribed audio recordings of the responses to the empowerment questions from the individual post-intervention interviews. The methods used to analyze data pursuant to aims 2 and 3 are described below.

**Mixed Methods Data Analysis : Aim 2**

There were three sources of data collected to evaluate the acceptability and feasibility of the intervention. The first source was demographic data gathered in the questionnaire which was administered during the first intervention session. This demographic data included age, years in nursing, number of intervention sessions attended, educational degree, years on critical care, type of unit, time since moral distress event, AACN membership, administrative support, ethics referrals, ethics education, and moral distress education. Descriptive statistics were used to calculate means for age, years in nursing, educational status, and years in critical care nursing. The second data source was the transcribed audiotapes of the feasibility questions from the post-intervention interviews. The third data set was the correlation coefficients between numbers of sessions attended and all other outcomes.
To determine if there was any relationship between demographics and feasibility and acceptability, the responses from the feasibility open-ended questions were evaluated alongside the demographics mentioned above. Because of the small sample size, the researcher was able to compare answers from the feasibility and acceptability open-ended questions with responses to demographics using the letter code of each person. For example, the researcher looked at the answers to the feasibility questions of the participant with Code letter A, and then compared this information to the demographic data connected to Code letter A on the SPSS file. This same process was completed for the rest of the sample, continuing with codes B- M. The third data source was information related to implementation criteria as suggested by Tinkle-Degnen (2013) such as recruitment rates, drop-out rates, and description of adherence to procedures.

**Mixed Methods Data Analysis: Aim 3**

As mentioned previously, the data for aim 3 were both qualitative and quantitative, with three sources for qualitative and four sources for quantitative. The first qualitative data source was the written moral stories that were part of the first of three educational sessions. The second was the output from each of the three-group sessions, which included output on standardized instruments, written texts, and transcribed audio recordings of group-led discussions, and the third was the transcribed audio recordings from the individual post-intervention interviews. The five quantitative data sources for aim 3 were demographic data, recruitment and attrition data, the MDS-R, the PES, and the CWEQ-II.

**Qualitative Data Analysis**

There were three sources of qualitative data used to evaluate Aim 3. In the following section, these three sources will be explained in detail. The first data source were the moral
First Data Source

The first data source for aim 3 was the nurses’ written stories of moral distress. These stories were penned in response to an invitation to “describe the story or incident that happened within the last year that caused you moral distress.” The narrative analysis of the moral distress stories helped establish data about the nurses’ sources of moral distress, their behavioral responses, and the extent to which power and oppressive forces led to their morally distressing situations. The stories were analyzed using thematic analysis methods (Creswell & Plano Clark, 2011b; Riessman, 2008a) that focused on both content (what was said) and structure (format of the stories, the way the stories were told). Findings were then compared across cases and reported. Using thematic analysis of both content and structure provided a form of triangulation that helped strengthen the credibility of the findings based on the narrative data (Creswell & Plano Clark, 2011a; Riessman, 2008a).

To perform the thematic content analysis on the stories, the hand-written stories were re-typed verbatim with one sentence per line. This was done to prepare the sentences for coding. The thematic content analysis of nurses’ written stories of moral distress was performed in two cycles, first, coding, and second, theming. The first cycle of analysis began with descriptive content coding, following the approach described by Saldaña (2013), who notes that descriptive content coding summarizes, in a word or short phrase, an important idea in the data. Two types of codes were assigned during the thematic content analysis: deductive codes and inductive code (Saldaña, 2013). A deductive code is one that is intentionally looked for based on previous research on moral distress (Saldaña, 2013). In
other words, a code that one would expect to find based on previous research or experience (Saldaña, 2013). Based on both quantitative (Oh & Gastmans, 2015) and qualitative (Huffman & Rittenmeyer, 2012) literature reviews, examples of deductive codes in this analysis were *sources of moral distress, response of the nurse,* and *oppressive power dynamics.*

Inductive codes are codes that are generated from the data as it is read and reread (Saldaña, 2013). There are several ways in which inductive codes get generated. Examples of these being: *in vivo,* which is a code created from a word or phrase found in the actual language, *emotion coding,* which is a code that labels the emotions described by the participant, and *values coding* which reflects values, attitudes, or beliefs (Saldaña, 2013). Two examples of inductive codes obtained from this data were *futility* (emotion code) and *patient suffering* (in vivo and emotion code). The first round of deductive and inductive codes in this thematic content analysis resulted in over 157 codes. The second cycle of descriptive content analysis began by taking the codes and developing themes from them. According to Saldaña (2013), themes are extended phrases or sentences that categorize what a unit of data means. As recommend by Hart (2005), themes in this study were developed from the codes by creating and examining visual displays, including mapping and diagramming, to see relationships between codes (Hart, 2005).

Once the process of mapping and diagramming was completed, it was discovered that one of the themes called *power dynamics* consisted of a very broad array of codes assigned to it. For example, inside of this theme were broad code topics such as *family,* *organization,* *physician,* *patient,* and *nurse,* which indicated that these broad categories in the moral distress story were impacted by the topic of power. For some, the physician,
organization, and family exhibited power in the moral distress story, and for others the patient and nurse exhibited a lack of power.

A second type analysis applied to the moral distress stories was structural analysis. Structural analysis evaluates the ways the words in the stories are organized by the storyteller and may shed light on the experiences of the storyteller in a way that the content of the work cannot (Riessman, 2008b). Structural analysis evaluates how a storyteller attempts to convince a listener that a chain of events happened and gives insight as to that individual’s experience. Structural analysis can also be used to evaluate how storytellers use speech to construct themselves and their histories (Riessman, 2008b). By evaluating the nurses’ moral distress stories through their telling of the chain of events, insight can be obtained on how these nurses made sense of the morally distressing situation (Riessman, 2008b).

As mentioned previously, structural content analysis was performed using Labov’s model of structural analysis. The application of Labov was similar to that of Robinchaux, in her study on critical care nurses and ethical climate (Labov, 1972; Robinchaux, 2003; Robinchaux & Clark, 2006). To analyze the nurses’ stories structurally, I examined how clauses within stories affected the overall narratives. Labov’s structural approach focuses on understanding the function of a clause or segment of narration within a narrative and the communicative work it accomplishes (Riessman, 2008b). Clauses were defined according to Labov’s six elements: Abstract (AB) summary or point of the story; Orientation (OR) provides time, place, situation, participants; Complicating action (CA) sequence of actions, turning points, crisis, problem or plot; Evaluation (EV) Narrator’s commentary on the complicating action; Resolution (RE) Resolves plot; Coda (CODA) Ends narrative; returns
listener to present (Riessman, 2008b).

The codes indicate the function of the clause in the overall structure of the narrative or does the clause carry the action forward (CA), comment on the meaning of an event for the narrator (EV), provide information about setting and character (OR), or resolve the narrative (RE) (Riessman, 2008b).

Labov’s structural analysis method was performed on all 13 moral distress stories. To do this, the participants’ handwritten stories from the intervention were collected and retyped sentence by sentence. Each sentence from the story was examined and assigned a clause from one of the six elements from Labov as described above. The stories were put into a graph with the participant codes across the top and the story sentence lines along the side. Next, the codes were color-coded (AB, OR, CA, EV, RE, and CODA) and analyzed to see if an overall structural pattern was found for the stories collectively.

**Second Data Source**

The second data source for aim 3 included output from standardized instruments and written texts and transcribed audio recordings from the three-session conscientization intervention. The data was analyzed by evaluating each group’s decodification of their moral distress stories though the sessions of Critical Reflection, Critical Motivation, and Critical Action, the learning stage, and how participants shifted in their awareness of and response to oppression over time.

**Third Data Source**

The third data source for aim 3 was the responses to the post-intervention interviews to evaluate the impact of a conscientization intervention on nurses’ sense of empowerment.
The data was analyzed by evaluating responses on the post intervention interviews, selecting specific quotes and summarizing these responses.

**Quantitative Data Analysis**

The demographic questionnaire, attendance and retention rates, correlations, and three measurement tools—MDS-R, PES, and CWEQ-II—provided data for the quantitative results. IBM SPSS Version 24 was used for all quantitative data entry and analysis, with the exception of effect size and post hoc sample size where G*Power Version 3.1 was used. Descriptive statistics were used to define the demographic data. Spearman’s correlation coefficient for non-parametric samples was calculated at .05 significance, and the results were reported. To report on overall pre- and post-intervention levels for moral distress, psychological empowerment and structural empowerment mean scores were calculated. For moral distress, pre- and post-MDS-R total mean scores, pre- and post-MDS-R frequency mean scores, and pre- and post-MDS-R intensity mean scores were reported. For psychological empowerment, pre- and post-PES total mean scores were reported, and for structural empowerment, pre- and post-CWEQ-II mean scores were reported. Overall mean levels for moral distress, psychological empowerment and structural empowerment were displayed in a table.

In addition to the overall pre and post MDS-R mean scores, five individual items from the pre-intervention MDS-R scale were selected and evaluated individually. The rationale for choosing these six specific MDS-R items was that they consistently matched corresponding topics that were discovered in the thematic and structural analysis of the moral distress stories. For example, the thematic and structural analysis of the moral distress stories revealed themes linked to futility of care, family issues in futility of care,
prolongation of suffering, and extraordinary means of care. Three examples from the five MDS-R selected items that corresponded to these themes were: MDS-R Q3—(family wishes continue life support I believe not best interest for the patient), MDS-R Q4—(initiate extensive life-saving actions I think only prolong death), and MDS-R Q6—(carry out MD orders I consider to be unnecessary tests and treatments). The specific items for MDS-R were chosen from the pre-intervention tool scores because it served as a baseline before the intervention.

Evaluation of individual items from both the pre-intervention PES and pre-intervention CWEQ-II scales was performed as well. Six individual items were chosen from both the PES and the CWEQ-II because they matched the thematic and structural analysis of the moral distress stories. Two examples of individual items selected items from the PES were: “autonomy to do the job” and “I have great control of what happens in my department,” and two examples of selected items from the CWEQ-II were: “Access to support helpful problem-solving advice” and “access to support comments for things to improve.”

To determine differences in pre- and post-intervention moral distress levels, psychological empowerment levels, and structural empowerment levels, related samples Wilcoxon Signed Rank Tests for non-parametric samples were calculated on pre- and post-MDS-R mean total scores, MDS-R mean frequency scores, and MDS-R mean intensity scores, pre- and post-PES mean level scores, and pre- and post-CWEQ- II mean level scores. Measurement of effect for the Wilcoxon Signed Rank Tests was measured using Cohen’s dz, and reliability for the Wilcoxon Signed Rank Tests was measured by Cronbach’s alpha on all Wilcoxon Signed Rank Tests and described in the results.

**Convergence**

107
As noted previously, using the parallel-databases variant of convergent design, the qualitative and quantitative data were first conducted and analyzed separately, and then the two sets of findings were brought together for congruency or discrepancy (Creswell & Plano Clark, 2011a). This is a convergent mixed methods design with an underlying transformative purpose which is to help address injustices or bring about change for a marginalized group—in this case, nurses who suffer moral distress (Creswell & Plano Clark, 2011a).

For aim 2, to determine feasibility and acceptability, the demographics, attendance records, attrition rates, and correlational data were compared and contrasted to the results from the post intervention interviews on participants’ perception of the implementation, acceptability, and practicality of the intervention.

For aim 3, the convergence of the data occurred on several levels. First, to determine sources of moral distress, the overall mean MDS-R scores and scoring on selected individual pre-intervention MDS-R items were compared and contrasted to themes from the moral distress stories. Second, to evaluate the participants’ perception of empowerment, the overall mean PES and CWEQ-II, and individual items from pre-intervention PES and CWEQ-II were compared and contrasted on responses of the post-intervention interviews. Third, to determine if the intervention impacted moral distress levels and perceptions of empowerment, the Wilcoxon Signed Rank Tests were run on pre- and post-MDS-R mean frequency, and intensity total scores, as well as pre- and post-PES mean level scores, and pre- and post-CWEQ-II mean level scores. These scores were compared and contrasted to the outcomes of the three-session interventions and post-intervention interviews.
In summary, the transformative convergent model allows for a mixed methods approach to evaluate the conscientization intervention for feasibility, acceptability, and initial outcomes. The design has a transformative purpose, in that it was guided by a perspective focused on change, specifically through the principles of conscientization developed by Paulo Freire (1995) in *Pedagogy of the Oppressed*, which occurs in a group process of critical reflection and dialogue.

**Reflexivity**

This chapter concludes with a discussion on reflexivity. Reflexivity involves an introspective process whereby the researcher reflects and evaluates if their personal biases had any impact on the study’s findings (Riessman, 2008c). During this reflection, the researcher turns the lens on themself to recognize and take responsibility for their situatedness within the research (Berger, 2015; Mantzoukos, 2015). As the researcher, I came from a shared experience position (Berger, 2015), meaning that I was in a similar position as the participants. I am a clinical nurse, and I have also experienced moral distress in my career. Being from this position placed me in an insider role which equipped me with insights, but also carried the risk of clouding boundaries and projecting bias (Berger, 2015). One such potential bias called confirmation bias, can occur where a researcher evaluates the data in a way that helps sway or confirm their hypotheses as relevant while dismissing evidence that doesn't support their hypotheses (Nickerson, 1998). To help control for confirmation bias, it was imperative for me to reflect on how my current and former work roles and experiences might influence my interpretation of data (Riessman, 2008c).

I practiced reflexivity by examining and acknowledging certain assumptions that I brought to the research I brought two assumptions to this study: first, I believe that most
staff nurses do not feel empowered, and second, I think that most staff nurses feel oppressed. I no longer work directly with patients and therefore do not currently risk having my own morally distressing experiences, despite having had some in the distant past. A nurse for 38 years, I spent 36 of those years in critical care and medical-surgical nursing. I have also mentored other nurses in a clinical area and have close relationships with nurses who have experienced moral distress.

Because of these aspects of my experience, as recommended by Wilkie (2015), I kept a diary during the study and wrote notes reminding me to not act on those assumptions. This diary also helped me keep perspective on my purpose as a researcher and my experiences as a nurse. I made use of the diary while reading and while analyzing data and outlining the findings, conclusions, and recommendations. I also did not have a hierarchical relationship with the nurses that I studied, and my relationship was akin to that of a peer.

In a final note, the exercise of researcher reflexivity was of particular importance in this study because the intervention’s purpose was to guide the participants through a process of self-awareness and reflection. While the participants are practicing self-awareness, it was imperative for me, as the researcher, to do so.
CHAPTER 4

RESULTS

In this chapter, I present the results from the conscientization study. The qualitative data will be presented first, followed by the quantitative data, then concluding with convergence of the two. First, demographics of the sample are presented. Second, I report the results of the qualitative data appraising the feasibility and acceptability in the form of summarized responses from interview questions. Third, I report on qualitative data evaluating the initial outcomes of the intervention as presented through three data sources: (a) the thematic and structural analysis of the moral distress stories, (b) output from group work within the problem-posing conscientization intervention as exemplified through Group 1, and (c) the summarized post-intervention interviews.

Next, I present the quantitative data results. First, I report on quantitative data for recruitment and dropout rates, as well as correlations used to evaluate the implementation for feasibility and acceptability. Second, I evaluate the effect of the intervention on moral distress, psychological empowerment, and structural empowerment by presenting survey mean scores, individual scores, and Wilcoxon signed rank test for MDS-R, moral PES, and CWEQ-II. Finally, I present the outcomes of the qualitative and quantitative data for convergence or divergence.

Demographic Data

The sample consisted of 13 critical care nurses from the Greater Cincinnati area, employed at three large hospital systems and in four different types of critical care units. The sample was all-female, with ages ranging from 24 to 61 years, and a mean of 38 years. The years of nursing experience ranged from two to 38 years, with a mean of 15 years.
Three nurses had an associate degree (ADN), eight had a bachelor’s degree (BSN), and two a master’s degree (MSN). Seven of the nurses had less than 5 years of experience as a critical care nurse. Membership in the American Association of Critical Care (AACN) was chosen as a variable because of the organization’s intent to educate and prevent its membership on moral distress (AACN, 2004). Out of the sample, five were members of AACN, with only two who are actively involved in the organization. Of the 13, three nurses had ever referred a patient for an ethics consult, even though seven had been exposed to education on ethics and ethics consult referrals. Four nurses had received education on moral distress, and two of the 13 reported that they felt supported by administration regarding ethical issues. Seven nurses reported a morally distressing experience that happened within the last year, while six reported an incident that happened within the last two to five years.

Spearman’s rank correlation coefficient tests showed that age was positively correlated with years in nursing, \((r_s = .918, p = .000)\), and years in critical care nursing, \((r_s = .834, p = .000)\). Positive correlations were also found between those that have had education on moral distress and referrals to ethics consults, \((r_s = .920, p = .030)\); between type of unit and having moral distress education, \((r_s = .608, p = .027)\); and between having had ethics education and moral distress education, \((r_s = .617, p = .025)\); and age and post PES scores \((r_s = .722, p = .005)\).

**Aim 2: Feasibility and Acceptability**

Responses to the post-intervention questions related to feasibility and acceptability were evaluated against demographic data associated with the corresponding participant code to determine if there were any relationships between demographics and feasibility and
acceptability. No trends were identified in comparison of these two sets of data. Feedback regarding acceptability and feasibility was positive from all participants, regardless of the demographic data.

The post-intervention feasibility and acceptability questions are summarized below and aligned with the feasibility criteria identified by Bowen et al. (2009). Acceptability is the evaluation of the recipients’ reaction to the intervention, and practicality explores the extent to which an intervention can be delivered with resources, time, and commitment (Bowen et al., 2009). There were seven questions in the post-intervention survey pertaining to feasibility and acceptability, with four evaluating acceptability criteria, three evaluating practicality criteria, and one item about implementation. Below are summarized responses from 13 interviews. As shown in Table 1, I chose selected quotes from the interviews that exemplified a variety of the nurses’ feelings and viewpoints as well as a summary from each question.

Table 1

<table>
<thead>
<tr>
<th>Acceptability Criteria</th>
<th>Question</th>
<th>Selected Quotes</th>
<th>Quotes</th>
<th>Summaries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptability Criteria</strong></td>
<td>15. What is your satisfaction with the length of the overall program and individual sessions?</td>
<td>“It zoomed by.”</td>
<td>“Never felt like they needed a break.”</td>
<td>“Had plenty of time to get all of the group discussion and assigned work done.”</td>
</tr>
</tbody>
</table>

113
“Yes, I thought it was very appropriate, either two or three sessions.” Participant J
“Yes, I think it would be great to do a week-end retreat.” Participant E
“Yes, I was very happy with it.” Participant D
“Yes, I would have liked to have had the article as not a homework assignment, but maybe presented and discussed in class.” Participant H

Summary
Overall, the participants’ responses indicate they were pleased with the length of the program. It was noted that a two-day program might be considered as well. A week-end retreat was suggested as well.

Question
16. Was the flow of information logical to you?

Quotes
“I liked how we picked one topic, then focused on it, then breaking it apart, that was really cool and helpful, and I think productive.”
“Yes, the explanations were very clear.”
“You were there to help everyone, so it was very logical.” Participant C
“Even though I was only able to make two sessions, you made it able to where you could catch up.” Participant L
“The small groups of three or four just seemed to work out well.” Participant L
“Yes, sorry I had to miss one, but it all came together in the end.” Participant B
“Yes, and I even missed one day but was able to catch up.” Participant J
“Yes, I like how everything kind of tied in together – the articles, the learning, the discussions.” Participant E
“Yes, I was able to follow along very well.” Participant D
“Yes, definitely make sense to me.” Participant H

Summary
All participants said they felt that the flow of information and structure of sessions was understandable and logical. Overall, they liked the detailed explanations and tools that were used, and they thought that everything flowed logically.

Question
17. What, if anything would you change about the intervention?

Quotes
“Would have liked it to go on longer.”
“If we had more time to write a longer story perhaps. I think people could write a journal about this honesty.” Participant L
“I thought the length was perfect, liked the amount of time that we were there. I like how everybody participated and we had a good group.” Participant B
“Nothing immediately comes to mind.” Participant C
“Maybe giving people more time to write their moral distress stories, but I don't know” Participant J
“Maybe like a week-end retreat.” Participant E
“I would have liked to have more time to write the moral distress story.” Participant H

Summary
The participants were generally satisfied with the program. There was a suggestion about the journal article and homework assignment, wherein the participants felt it would have
been beneficial to either provide time during the intervention to read the article or to provide a bullet-point summary of the article for the group to help answer the journal article questions. Several people would have liked more time to write their moral distress stories, giving to the notion that that should be worked into sessions, or perhaps taking home and journaling instead.

**Question**
18.
Were there any specific topics covered that you were not comfortable with?

**Quotes**
“No I felt very safe during the program.”
“We were all in it together, and I like hearing the other stories.”

**Practicality Criteria**
19. Were the surroundings comfortable?

**Quotes**
“I think this place is awesome.”
“This was a nice central location.”
“I got lost the first day but that had nothing to do with the location or parking.”
Participant C
“No, I thought that it was all very private and safe place to talk.” Participant J
“No, no problem.” Participant E
“No I was very happy with the physical location, it was private, there was food.”
Participant D
“I was very happy with the location I didn't think it was too far away or anything.”
Participant H

**Summary**
All participants indicated satisfaction regarding location and felt that the room was comfortable and provided a safe space for the intervention.

**Question**
21. Can you tell me why you were not able to attend all three sessions?”

**Quotes**
“I am sorry, I would have really liked to attend, it was out of my hands.” Participant F
“My babysitter fell through at the last minute.” Participant B
“The first day I got called into work.” Participant C
“I got really sick on the morning of the session.” Participant J

**Summary**
Their reasons for not attending included a death in the family, two cases of illness, one case wherein their child was sick, and on had an emergency with a babysitter, and two were called into a work mandate. In the post intervention individual interviews, participants who only attended two sessions nevertheless felt they were able to catch up with the content and participate in the intervention in a meaningful way.
**Aim 3: Impact of a Conscientization Intervention**

In the following section, the results from the three sources of Aim 3 will be discussed. The first source is the thematic and structural analysis from the moral distress stories. The second source are the results from the three group interventional sessions, and the third is the results from post-intervention interviews.

**Moral Distress Stories**

The first data source for analysis of finding for this specific aim was the moral distress stories. Both thematic and structural approaches were used in analysis of story data. Thematic analysis provided baseline information on the participants’ overall sources of moral distress, their behavioral responses, and the extent to which power and oppressive forces impacted their development of moral distress. Below, I present analysis of the written moral distress stories and analysis of transcriptions from the group discussions. First, I give a description of the thematic analysis process that I used, followed by a summary of thematic results from analysis of all 13 moral distress stories. All raw data from the thematic analysis is featured in Appendices W- II.

Next, I provide a table containing all the themes, corresponding subthemes and related codes along with quotes from the stories that exemplified each specific theme. After presenting my processes of thematic analysis through the tables and a diagram, I give results of the structural analysis that I applied to determine how the storytellers processed the problems they described. Finally, I summarize the analysis of transcriptions and output from the three-session intervention, using Group 1 as the exemplar.
Thematic Analysis Results

The analysis of moral distress stories started with three deductive codes, namely, source of moral distress, response of the nurse, and power dynamics. As previously described, deductive codes were derived from literature on moral distress in nursing (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). A first cycle of reading and rereading was performed, and 157 inductive codes were derived. These 157 codes were subsequently analyzed for repetition and overlap. By condensing, compiling, and eliminating redundancies, the original code list was reduced to 35 codes, resulting in four themes from a second cycle of analysis.

The first theme — “Source of moral distress” — was derived from codes acquired from the stories about patient care situations involving futility of care, and aggressive care against patient wishes, and unsafe care. In the moral distress stories, futility of care was described in relation to the use of chronic ventilator units in an incurable pulmonary condition, aggressive treatment of patients with metastatic cancer with no hope for recovery, and aggressive care for chronic comorbidities in extreme elderly patients, among others. One nurse wrote in her moral distress story about an elderly patient with end-stage renal failure who was septic and had necrotic feet up to the knees. She stated, “She wasn’t going to recover, but we kept doing treatment on her anyway.” An example of aggressive care against patient wishes involves a description of a COPD patient who was frequently admitted to the hospital on a chronic ventilator by describing, “She did not want to continue with care, but her family insisted, and no one would do anything about it.” Additionally, an example of unsafe care was relayed by one nurse: “My patient was admitted from the ER
with a tracheostomy that we could not take care of, the doctor ignored us, and it was so unsafe.”

The second theme — “Response of the nurse” — was derived from codes obtained from the stories related to descriptions on how nurses felt while trying to survive with moral distress. Nurses’ stories reflected both somatic and psychological responses and involved nightmares and feelings of frustration, sadness, detachment, guilt, remorse, and numbness. As one nurse described, “I felt like I was going to throw up, I had nightmares for a long time, and I felt helpless.” Another nurse shared what she had experienced: “I was so upset that I had the manager take over the care of my patients” and another noted: “It was kind of a numbing experience.”

The third deductive theme—“Power dynamics”—was derived from codes obtained in the descriptions of power struggles between various parties involved in decisions about patient care. Sub-categories from the power dynamics theme are families, the organization, physicians, patients, and nurses. The connections to power and the dynamics between these subthemes are interconnected. For example, illustrations of this theme involved struggles that occurred within families and included family members’ insisting on care that the patient did not want or bullying staff into giving a specific type of care to the patient. Power struggles between administration from the organization were evident in stories in which participants described hospital administration countenancing inappropriate behavior by physicians and families. Power struggles between nurses and physicians documented physicians who demanded that as one nurse phrased it as, “They would not resuscitate patients or who did not order a palliative care consult even when requested by nurses on behalf of a family.”
Other examples of this theme were found in stories about physicians who displayed their power by creating situations wherein they did not communicate with families as expected, leaving the responsibility to nurses. Participants also touched on this theme in describing patients’ lack of power, as when patients’ wishes were dismissed, either by their families overriding them or physicians ignoring them. One nurse’s story exemplified this theme:

The most recent event that was distressing had to do with a 99 year-old Asian patient who was from a long term care facility. She had a tracheostomy, was on a ventilator and unresponsive. She would open her eyes spontaneously but that was all she could do. Her family demanded everything be done for and she was a full code. Multiple tests and treatments continued to be done. All week the physicians refused to address the issue of her age, vegetative state. No palliative care was ordered. We were frustrated because the family was demanding answers. The nurses were left to fill in the answers and gaps the physicians refused to talk about. (Participant K)

The fourth theme—Lack of resolution—related to the amount of unresolved energy expended in trying to act as a moral agent, such as one nurse who said, “After a week of asking for it, Palliative care still wasn’t ordered.” It took months to enact a DNR status according to another nurse who said, “Patient code status was changed to DNR after 3- 4 months of ethics and multiple meetings with daughter, administration.” In addition, the structural an. See Table 2 for thematic analysis breakdown.

Table 2

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes/related codes</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sources of Moral Distress</td>
<td>Futility of care clinical situations</td>
<td>“Pt. in hospital for multiple weeks and not really doing anything to improve quality of life.” Participant D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“She [the patient] just had a very poor quality of life.” Participant E</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Prolongation of life</td>
<td>“Her [the patient] family demanded everything be done for her and she was a full code.” Code K</td>
<td></td>
</tr>
<tr>
<td>Multiple invasive procedures</td>
<td>“[The family] continued life prolonging treatments, multiple cardiac arrests, and Continuous Renal Hemodialysis Therapy.” Participant K</td>
<td></td>
</tr>
<tr>
<td>Extreme measures not wanted by the patient</td>
<td>“Multiple tests and treatments continued to be done.” Participant K</td>
<td></td>
</tr>
</tbody>
</table>
| Unsafe Care/Unsafe situation             | “I was told that the patient was admitted with respiratory distress and that the ED attempted to increase the size of the patient’s tracheostomy.” Participant F  
“I was so upset that I had the manager take over the care of my patients.” Participant H  
“I felt terrible that I had to restrain a patient at the end of her life.” Participant I  
“It was kind of a numbing experience.” Participant C  
“I was having forgetfulness and giving unsafe care.” Participant L  
“I didn't want to come back to work. Wasn't sure that I could come back to work.” Participant L  
“I felt terrible that they [the family] didn't have enough respect for their father to take care of him.” Participant M  
“I was so drained and frustrated by the end of |

<table>
<thead>
<tr>
<th>Response of the nurse</th>
<th>Nightmares</th>
<th>“I had nightmares for a long time.” Participant E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anger</td>
<td>“I was so upset that I had the manager take over the care of my patients.” Participant H</td>
</tr>
<tr>
<td></td>
<td>Sadness</td>
<td>“I felt terrible that I had to restrain a patient at the end of her life.” Participant I</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes/related codes</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness</td>
<td></td>
<td>“It was kind of a numbing experience.” Participant C</td>
</tr>
</tbody>
</table>
| Remorse |                           | “I was having forgetfulness and giving unsafe care.” Participant L  
“I thought I was going to throw up.” Participant E |
| Shame |                           | “I didn't want to come back to work. Wasn't sure that I could come back to work.” Participant L |
| Outrage |                           | “I felt terrible that they [the family] didn't have enough respect for their father to take care of him.” Participant M |
| Frustration |                         | “I was so drained and frustrated by the end of |
the day.” Participant K
“We [the nursing staff] were frustrated because the family was demanding answers.” Participant K

Detachment
“We felt guilty working on a patient to revive her and she [the patient] doesn’t want to be revived.” Participant I

Guilt
“My moral distress is that I regret on this is placing patient on bi-pap and restraining them [the patient].” Participant I

Regret
“Patient unresponsive since intubation, but daughter, who was a lawyer, and MDs and administration were afraid to confront her [the daughter].” Participant I

Powerlessness
“Patient unresponsive since intubation, but daughter, who was a lawyer, and MDs and administration were afraid to confront her [the daughter].” Participant I

Helplessness
“I felt helpless.” Participant E

Power Dynamics
Family- won’t follow patient wishes. “I believe the patient is wanting to die but the family will not let her go” Participant B

Family Unrealistic expectations
“Palliative care not able to reason with one of the family members.” Code D
“They [the family] couldn’t or wouldn’t comprehend how sick their wife/mother really was,” Participant J

Family Abandonment
“Family not in see the patient. Family not calling or checking on patient.” Participant D

Family Elder abuse
“The most complex dynamic of this was her daughter.” Code G
“His family was unable or unwilling to care for him.” Participant M

Themes
Sub-themes/related codes
Quotes

Organization- No support
“Organization [hospital administration] side with the family.” Participant G

Organization Side with powerful family
“Disappointed in administration – because we [the hospital] were promised a big donation from daughter- haven’t seen yet.” Participant G

Physician No DNR
“The physician proceeded to yell at me and refused to change the code status.” Participant F

Physician No Palliative Care
“No palliative care was ordered,” Participant K

Physician Taking orders from family
“The daughter would call up the physicians and they would take orders from her!” Participant A

Patient Forced into care
“The patient always seems angry and sad that she is in the condition that she is while she is...
| **Patient** | Not allowed to die | “She wanted to die, and her family called her selfish and thought there was still more life for her.” Participant J |
| **Patient** | Wishes not followed | I’ll never forget the phone I made to the phone call that I had to make to the patient’s daughter that morning because we discussed what the patient would not have wanted that.” Participant F |
| **Nurse** | Not being supported | “The doctor refused to order a DNR.” Participant F |
| **Nurse** | Being ignored | “All week the physicians refused to address the issues of her age, vegetative state.” Participant K |
| **Nurse** | Fear of family | “Of course, we [the nurses] were afraid of a lawsuit from the daughter, so it was the best code we ever performed.” Participant G |
| **Lack of Resolution** | Nurses advocating care | “The nurses were left to fill in the answers and the gaps the physicians refused to talk about.” Participant K |
| Palliative care efforts | “After a week of asking for it, Palliative care still wasn’t ordered.” Participant K |
| Ethics committee results | “Patient code status was changed to DNR after 3-4 months of ethics and multiple meetings with daughter, administration. “Code K We consulted Ethics after like a month.” Participant C |

**Structural Analysis Results**

I found that all 13 moral distress stories commenced with the nurse either summarizing what had happened in an abstract (AB) or providing an observation (OB) that identified the location, situation, and participants involved. Next, all the storytellers moved into the complicating action (CA) or the sequence of the action that caused the moral distress, including its turning point, crisis, or problem. Next, my analysis showed that after the initial complicating action, the narratives followed one of two structures. Most (n = 10) of the stories went directly into the nurse’s evaluation (EV) or assessment of the critical action. When the clauses that followed the CA (n= 3) did not progress into evaluation, they
were coded as observation statements (OB). In these, the participant offered an observation about the complicating action, after which the narrators went into the evaluation of the complicating action.

Further analysis revealed that in the stories that were longer in length, there was a cyclical pattern of repeating secondary critical actions (CA), followed by either EV or OB. Only six of the stories included any sort of resolution clause (RE). Of these six, four stories ended in a resolution statement, while in the other two, the resolution was embedded in the middle of the story, followed by additional complicating actions, indicating that the participants did not feel the situation to be resolved. The coda, which should end the narrative and return the listener to the present, was seen in 11 of the 12 stories, though in varying places. Eight of the participants’ stories included the coda at the end of the story, while four had a coda close to the end but was followed either by more observation or evaluation.

Structural coding revealed there were comparable patterns in how nurses sequenced the distressing experiences in their moral distress stories. The structure of the stories supports two claims: First, the cyclical pattern and absence of resolutions in so many narratives highlight how nurses often fail to reach closure in morally distressing situations. Perhaps they are still processing the flow of events in their stories or remain unresolved about the event subconsciously. Second, the lack of consistent placement of codas suggests that the storytellers could not bring their stories to the present, because the way the stories ended was not part of the present as they would like it to be. The table displaying the structural data analysis is in Appendix JJ.
Aim 3: Three Group Sessions

In the following section, I present an exemplar based on Group 1 of the detailed data from analysis of written transcripts and transcribed audiotape from the three educational sessions dated October 10, 2017 (Session One), October 17, 2017 (Session Two), and October 24, 2017 (Session Three). Each session contained three groups (Group 1, 2, 3) that completed the sessions simultaneously. The summary of analysis of transcriptions and output from Group 2 (see Appendix KK) and Group 3 (Appendix LL).

During Session One: Critical Reflection, each participant from the small groups got to know each other by sharing information using the tool “Understanding Ourselves.” Next, each participant wrote a personal moral distress story and shared that story with the large group. Then, each small group picked one story within their group to be used to evaluate three foci of culture, power, and resources. To end the session, each group weighed options for what could have been different or could have been done differently to avoid moral distress.

Session One: Critical Reflection

The participant goals for Session One were to (a) share personal stories about their culture, power, resources, motivations, and ideal visions for society; (b) codify and share their moral distress stories; (c) decodify the moral distress stories within the context of the awareness of the culture, power, resources, motivations, and ideal visions for society, and (d) categorize elements of the moral distress stories into one of two options determining “what made the situation worse” or “what would make the situation better” and then reflecting on options for response or action.
Learning stage: understanding ourselves. The first learning stage for Session One is titled “Understanding Ourselves,” (Freire, 2016). The purpose of this exercise is for individuals in each small group to get to know each other on a personal level so that they can understand each other’s everyday lives. This is done because problem-posing education is a group process that relies on personal experience to produce social togetherness and mutual concern for change (Blackburn, 2000; Wallerstein & Auerbach, 2004).

Group 1 had two participants, both of whom were from the Cincinnati area and had lived in Cincinnati their entire lives. They were both married, did not have children, and labeled themselves as nurses and wives. They were both influenced to become nurses by a family member (by an aunt and a mother, respectively). They differed in their educational levels, wherein one had a master’s degree in nursing and the other had an associate degree. One of the nurses worked in a telemetry unit (Tele) and the other worked in a medical intensive care unit (MICU). They both identified outside involvement and hobbies as volunteering and traveling. The two obtained their news in different ways, one by staying updated exclusively through social media, while the other made a point of saying that she had quit Facebook, did not engage in social media as much as before, and no longer watched the news. Both described their view of society as “Scary sometimes” and while both said that they generally loved people, both also had wariness of the Internet and the way media depicted people on the Internet.

As part of the Understanding Ourselves learning stage, (Freire, 2016) each participant was asked to write a moral distress story on a piece of notebook paper provided. Next, every individual participant read their story aloud to the entire large group, after which each small group chose one of the stories from their group to use in activities for the
remainder of the intervention. The purpose of this activity was to encourage the feeling of community and shared experience of having experienced moral distress. Below is the moral distress story chosen by Group 1 as written verbatim by Nurse F:

A little over a year ago, I was called with a new patient from the Emergency Room. I was told that the patient was admitted with respiratory distress and that the ED attempted to increase the size of the patient’s tracheostomy. Upon arrival to the floor he was in severe respiratory distress. A rapid response was called. After the patient was stabilized, I notified the attending physician of the rapid response. I requested that the patient’s code status be changed to reflect the patient wishes patient was listed as full code but wanted to be no code) The physician proceeded to yell at me and refused to change the code status. I requested that the patient’s code status be changed to reflect the patient wishes patient was listed as full code but wanted to be no code). The next morning the patient’s tracheostomy became dislodged and the patient arrested. A code blue was called, and CPR was initiated because the code status had not been changed yet. I’ll never forget the phone call that I had to make to the patient’s daughter that morning because we discussed what the patient would not have wanted. (Nurse F).

The group discussed how the nurse attempted to advocate for the patient, but was not listened to by the physician, how the charge nurse did not advocate to move the patient, and how the respiratory therapist did not know how to take care of the tracheostomy, and the physician did not listen to the nurses regarding the patient’s DNR status and how sick the nurses thought the patient was. This discussion was illustrated in the Learning stage:

Understanding what already exists.

**Learning stage: understanding what already exists.** Below, I present a schematic of the results that Group 1 completed using the template provided as part of the exercise for their choices for the foci of culture, power, and resources as related to their moral distress story (see Figure 5).
Following the group activity where the template was completed, Group 1 discussed their findings with the entire group of participants. Their analysis of the story highlighted several ways in which the story fit the three focal points of culture, power and resources.

First the group identified the physicians’ lack of respect for the nurses as an example of the culture focus. As stated by Nurse F “In the middle of the night the doctor wasn't very cooperative” and then added: “Just seemed like he was being very disrespectful and disregarding the patient wishes.”

Next the group identified several examples of power focus by the example of the physician’s lack of follow-up and ignoring the nurse’s advocacy for the patient’s wishes. Examples of this power foci from Nurse F are her words: “The patient was supposed to be a DNR, he even had the paperwork, but the physician refused to change the order in the middle of the night.” She went on to say, “The patient ended up getting coded and dying the next morning after his trach become dislodged, so it seems like the doctor had all of the power.” Nurse F added “Even though the nurse did try to advocate for the patient’s wishes
and the families wishes.” Finally, the group addresses the resources focus by describing the lack of resources at night and the inappropriateness of admitting a patient with a trach to a unit that is not familiar with them. Nurse F from Group 1: “Resources are very limited at night, and the doctor didn't even see the patient before admitting them to our unit.” She went on to observe, “Also, on the Telemetry floor, we’re not familiar with tracheostomies so when the situation happened, we really didn't know how to respond; even respiratory therapy had a difficult time.”

**Learning stage: weighing options.** The next learning stage Group 1 completed was called “Weighing Options,” Freire, 2016. In this learning stage, each group evaluated their moral distress story and compared two sets of options. The first option referred to the actions that made the situation worse; the second referred to actions that would have made the situation better. The purpose of this exercise was to encourage participants to think of options that might help correct a situation that could be applied in future instances. As presented in Table 3, the results from Group 1’s written exercise were in alignment with the template that was used during the exercise. This exercise was done within each small group and the results were presented to the large group.

Table 3

*Weighing Options Group 1*

<table>
<thead>
<tr>
<th>Made moral distress situation worse</th>
<th>Would make moral distress situation better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blame from management after lack of support from them to not admit patient to the unit.</td>
<td>Acknowledging patient wishes at admission.</td>
</tr>
<tr>
<td>Lack of knowledge by nurses and respiratory about tracheostomies in general.</td>
<td>More appropriate response from the physician.</td>
</tr>
<tr>
<td>Intimidating behavior of physician.</td>
<td>More support from management.</td>
</tr>
<tr>
<td>Physician not willing to listen to nurses.</td>
<td>Ability to obtain support override physician.</td>
</tr>
</tbody>
</table>
Session Two: Critical Motivation

The participant goals of Session Two were to (a) discuss homework assignment questions from the article published by Matheson and Bobay (2007); (b) envision future work scenarios through their newly acquired understanding of the causes of their powerlessness from the first session; and (c) use the three foci of culture, power, and resources, to evaluate generative themes related to the experience of moral distress in the hospital.

Journal article review. At the beginning of Session Two, the entire large group participated in a discussion of the article published by Matheson and Bobay (2007) titled “Validation of Oppressed Group Behaviors in Nursing.” This article introduced the notion of oppressed group behaviors and the culture of silence in nursing, as well as Freire’s (1995) concept that freedom from oppression cannot occur without awareness of one’s own oppression. The goal of this assignment was to provide the participants with information about oppression, power in nursing, and the culture of silence in nursing. With this information, a discussion was facilitated on the roles that oppression and power played in their experiences of moral distress. A secondary goal was to raise awareness in the nursing community about the concept of oppression and lack of empowerment. In addition, the article incorporated analytical knowledge that is sometimes part of the problem-posing education. In Table 4, questions from the Matheson and Bobay (2011) journal article homework assignment are presented followed by a summary of the responses provided by the participants.
Question 1. Did the article enlighten you in your understanding of oppression and power in nursing?
Quotes
“Yes, we are not equal, we are subservient and have no power unless we are on equal footing as doctors because we are not considered their equals, only subservient.” Participant I
“Yes.” Participant L, (age 62), Participant G (age 24), Participant K (age 51)
“Yes, interesting viewpoint” Participant A (age 27)
“Yes, I never really thought of it as oppression before, just as having to do what the physician wants.” Participant C (age 24)
“Yes, there is no power until we have equal footing as doctors.” Participant I (age 55).
Summary: Respondents agreed that this article enlightened them about oppression and oppressed group behaviors in nursing, particularly as they relate to bullying and horizontal violence. Most nurses had heard about bullying and horizontal violence but had not previously thought of them in relation to oppression.

Question 2. What did you learn from this article that you think influenced why this moral distress situation happened to you?
Quotes
“It’s a sense of oppression and powerlessness from multiple sources that made me feel distressed. I previously viewed it as lack of control, but maybe, it more of true powerlessness.” Participant C (age 24)
“Oppression in nursing is real, many nurses feel it every day.” Participant A (age 27)
“Not feeling empowered to do more about the situation.” Participant E (age 42)
“It correlated to ability to handle verbal abuse.” Participant L (age 62)
“Lack of nursing identity.” Participant G (age 24)
“I felt like I left my patient down. I had no control over the outcome, but I can’t blame that on being oppressed by other’s decisions.” Participant I (age 55)
“Feelings of powerlessness validated because no support or encouragement lead to moral distress.” Participant K (age 51)
Summary: The participants indicated that the article affirmed why they themselves had no control over the outcome of their moral distress situations and the welfare of their patients. They indicated feeling powerless in changing the situation or in helping the patient in any way. They also felt no validation or support from the physicians or administration for what they were trying to accomplish for the patients. At the end of this discussion, one of the participants stated, linking to what Freire (1995) called suffering-in-silence.

Question 3. Have you ever thought about this issue before?
Quotes
“No—and then yes—patients even say, ‘nurses do all the work and doctors get the thanks.’ It also seems that nurses advocate for patient rights”. (Participant I (age 55)
“Not exactly as a form of oppression, but I have thought of moral distress before”. Participant C (age 24)
“I now have a name to describe it.” Participant A (age 27)
“Honestly I haven’t. I have thought of being burnout before but not oppression or moral distress.” Participant E (age 42)
“Not really, I didn't have the language to describe the feelings I had.”
Participant K (age 51)

**Summary:** The participants’ responses were split on this question. Some said that they had not thought about oppression before reading this article, while others said they had thought of the reason nurses bully each other but did not have the context of oppression as a reference point to define them as such. Recognizing that what they had witnessed was bullying behavior in nursing, one of the participants stated,

**Question 4. Did you think that oppression or lack of power influenced this moral distress situation?**

**Quotes**
“Not in the way that the article explained it as general themes of oppression. I thought of it more as a lack of control than a real lack of power.” Participant C (age 24)
“The physician dismissed the nurse’s concerns, and because he held all of the power, so it didn't matter.” Participant K (age 51)
“Yes it definitely did as I cared for the patient for several weeks and felt lots of stress and helplessness.” Participant E (age 42)
“Policy and powerlessness dictated the outcome. I was given the power to continue CPR, and then stopped it when asked by the physician.” Participant I (age 55)

**Summary:** All the participants agreed that oppression or lack of power influenced their moral distress situation.

**Question 5. How does that make you feel? Can you elaborate on that?**

**Quotes**
“I think the lack of validation ant the powerlessness to change outcomes is frustrating.” Participant I (age 55)
“I am happy that the language of oppressions and lack of power has been written. I was just blaming myself for the angry, upset feelings.” Participant K (age 51)
“It made me feel really sick inside and sad that I couldn't do more. I didn't know how to deal with my emotions afterwards.” Participant E (age 42)
“It makes me realize that I have power on certain things, but as least I can be autonomous on some ways.” Participant C (age 24)
“Hospitals think they empower us with new changes, but really [we] feel more oppressed.” Participant A (age 27)

**Summary:** Feelings expressed included lack of validation, frustration, and sadness at not being able to do more. Several participants described being upset
and angry. Also, most described feeling alone, sickened, and at fault for the situation. Regarding power within the organization and administration changing in how nurses work, one nurse observed,

**Question 6: What do you think you can do about it?**

**Quotes**

“That is the problem, I have done nothing.” Participant K (age 51)

“I am feeling better about the fact that I can play a more active role in the decisions of the residents.” Participant C (age 24)

“Nothing, making a profit is the number one priority in the organizations.” Participant I (age 55)

“Learn from this situation and educate others on how to deal with this type of situation.” Participant E (age 42)

“Advocate for self or staff.” Participant A (age 27)

**Summary:** One nurse stated that she felt these themes meant that overall, nurses feel powerless and have low self-esteem without any awareness for why they feel that way. In their inability to first identify the problem, they then cannot make the necessary changes. Thus, this makes them feel even more powerless, and sometimes hopeless.

**Question 7: Do you see the connection between the effects from suffering moral distress?**

**Quotes**

“Between all of the stories—yes—futile care and lack of control of power over situations.” Participant C (age 24)

“I am sad because she used to love being a nurse.”

“Have frustration with the inability to change.” Participant I (age 55)

“Oppression of nurses, low self-esteem, empowerment.” Participant K (age 51)

“Yes, nurses are not empowered as we should be, and we deal with a great deal of stress and abuse from multitudes and were not taught how to cope.” Participant E (age 42)

**Summary:** They described the connection as a cascading of the effects, from the inability to cope with the situation to a possible burnout. Some expressions included and another felt that she was “starting to resent other staff members” or similar feelings related to lateral violence.

---

**Learning stage: understanding where we wish to go.** The first learning phase in Session Two is called “Understanding Where We Wish To Go.” In this learning stage, the participants envisioned future work situations where they could apply changes through their newly discovered understanding of the causes of their powerlessness from the first session. The three foci of culture, power, and resources are used again, however, in this exercise, the
participants looked at possible positive changes that could happen in the future. For the purpose of this exercise, we determined the “future” as the next ten years, the year 2027. A schematic of Group 1 for the learning stage “Understanding Where We Wish to Go” (Freire, 2016) is displayed (see Figure 6). The arrows in the schematic represent the notion that the three foci should all equally impact the envisioned 2027 institution. This exercise was done within each small group and presented to the large group with no group discussion.

Figure 6. Understanding where we wish to go Group 1

To review, during Session Two: “Critical Motivation,” the large group was led by the animateur in their discussion of the journal article published by Matheson and Bobay (2007). This article provided participants with information about oppression and power in nursing and inspired them to think about the roles that oppression and power could play on their moral distress experience. Next, each small group was asked to envision an institution in the future (2027) where they could apply changes that they had identified from Session One based on the three foci of culture, power, and resources. As described in Chapter 3, the
participants were assigned homework to read a journal article and answer some questions for discussion in Session Three.

**Session Three: Critical Action**

The goals for participants in Session Three were (a) discuss homework assignment questions from the article published by Fletcher (2006); (b) complete the exercise of Strategy Building, Planning, Resource-Acquisition, Implementation; and (c) create and present the action project.

**Journal article review.** The purpose of this exercise was to introduce the concept of self-awareness that can be achieved through reflection as a strategy to break the cycle of oppression and to initiate changes in the structures that oppress nurses (Fletcher, 2006). In addition, this article incorporated analytical knowledge that is sometimes part of the problem-posing education. As presented in Table 5 responses from questions from the homework assignment on the Fletcher, (2006) article, followed by the summary of the participants’ responses for each question are presented.

Table 5

*Homework Assignment Fletcher (2006) Journal Article Group Discussion*

<table>
<thead>
<tr>
<th>Question 1. Did this article help you examine how we might change how we think about ourselves and identify new possibilities for leading in nursing?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quotes</strong></td>
</tr>
<tr>
<td>“Yes, somewhat, embracing feminism is hard because with nursing being so primarily female, and males have always been the patriarchy.” Participant G (age 24)</td>
</tr>
<tr>
<td>“Yes.” Participant A (age 27), Participant k (age 51)</td>
</tr>
<tr>
<td>“I do believe self-esteem and self-worth does impact the workplace depending on how we are treated.” Participant E (age 42)</td>
</tr>
<tr>
<td>“What hurts nurses becoming leaders is that they have no idea of leadership or management skills.” Participant I (age 55)</td>
</tr>
<tr>
<td>“I think the pathway of how our thoughts and beliefs affect our performance was a good model and how we must change our self-image to change how we lead in nursing.”</td>
</tr>
</tbody>
</table>
Participant C (age 24)

Summary: The article encouraged participants to see the changes they needed to make regarding their self-image if they wished to change how they are treated and perceived by others. There needs to be more development in nurse leadership. They recognized that self-esteem and self-worth can move them to action, and that they needed to have discussions on how to facilitate communication between leaders and staff.

Question 2. Do you think this self-awareness is crucial if we are to change how we think about ourselves, and how we act and perform?

Quotes
“How can we act as leaders with our bad self-image in which we could be nurse leaders? How can a nurse appropriately advocate for a patient if we feel inferior or powerless? We must believe we are strong, empowered.” Participant C (age 24)
“Yes.” Participant K (age 51), “Yes” (Participant G (age 24)
“I agree self-awareness or self-identity is important before we can change or understand how we act or perform.” Participant I (age 55)
“Yes, very much so.” Participant E (age 42)
“Yes, it allow us to understand how we are viewed by others so we can influence them.” Participant A (age 27)

Summary: The nurses noted that they had not thought about the issue of self-awareness and how it affects the way nurses are portrayed, primarily because they hadn’t understood or thought of nurses being oppressed.

Question 3: Have you ever thought of this issue before?

Quotes
“No.” Participant G (age 24)
“Not really.” Participant K (age 51)
“Not in this context.” Participant A (age 27)
“There have been times that I have.” Participant E (age 42)
“Not applying it to nursing.” Participant I (age 55)
“Not really, definitely not in such detail as this article mentions.” Participant C (age 24)

Summary: Most of the nurses said that they really hadn’t thought of the issue before reading the article.

Question 4. Can you give me some examples of factors that influence our thoughts and beliefs as nurses?

Quotes
“Power as a nurse is inferior to the power of a physician. The focus is curative over caring. The shift to focus on the technical versus needs of the patient” Participant C (age 24)
“Our past experiences, the environment we grew up in, how we view ourselves.” Participant K (age 51)
“Our ethics, morals, culture, education, and open-mindedness.” Participant I (age 55)
“Interactions with staff, doctors, morals and values, recognition an compliments.” Participant E (age 42)
“Specific patient situations, basic human rights, our upbringing.” Participant A (age 27)
“Our identity, past experience, and hospital culture.” Participant G (age 24)

Summary: Sentiments shared by the participants on why nurses might feel inferior to physicians include the idea that physicians get more attention and credit for the patient’s recovery. Also, the participants discussed the notion that curing patients (the primary focus
of physicians) is generally considered more important that caring for them (the primary focus of nurses). With the focus on patient satisfaction and comfort, one participant related that she felt that nurses are not really appreciated by patients in today’s hospital setting.

**Question 5. Can you explain how dialogue and self-awareness can help nurses with the dual roles of leadership and oppression?**

**Quotes**

“Not allowing horizontal violence, remembering what it is like to be new.” Participant G (age 24)

“Empowers that nurses to have a voice and an awareness that their opinions and feelings matter.” Participant A (age 27)

“Know the signs of oppression and be aware of lateral violence.” Participant E (age 42)

“Communication is important in all we do we have to listen.” Participant I (age 55)

“As we become more aware of our experiences and feelings, we can be empowered to speak out.” Participant K (age 51)

“I like how this article said if we are self-aware and put our opinions aside. We must have self-awareness and real dialogue to really work together and collaborate.” Participant C (age 24)

---

**Learning stage: strategy building, planning, resource-acquisition.** In the learning stage of strategy building, planning, resource-acquisition (Freire, 2016), the participants evaluated their environment and work in terms of (a) individuals; (b) organizations; (c) institutions; and (d) government. The purpose of this learning stage is to help the groups evaluate and plan action projects that would yield achievable results. Those items listed in the “for” column refer to what or who can be helpful to their cause, and those in the “against” column refer to what or who can be unhelpful to the cause. Table 6 provides the result of Group 1’s exercise.

<table>
<thead>
<tr>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td></td>
</tr>
<tr>
<td>More RNs than MDs</td>
<td>RN gender mostly women and all that goes along with that such as</td>
</tr>
<tr>
<td>Potential power in numbers</td>
<td></td>
</tr>
</tbody>
</table>

**Table 6**

*Strategy Building, Planning, Resource-Acquisition, Implementation Group 1.*
Below, I report the results of the group discussion regarding Group 1’s Strategy Building exercise. In the individual focus, looking at experience and mentorship, one nurse pointed out, “It is important to mentor each individual to have respect and self-awareness and voice,” and another participant added, “The problem is that instead of the individual voice, we have a revolving door mentality.” Looking through the focus of organizations, and the control that is taken away from them a participant added, “a lot of the times the organization focuses on finance and patient satisfaction, while staff satisfaction takes a back seat to those things.” When discussing the institutional focus, examples given by the nurses were that rounding on patients was something that could help if, as one nurse said, “The institution gave bedside manner classes for physicians and some nurses.” Evaluating the effect of the governmental focus, one participant stated, “The health care industry kind of
lets certain insurances companies dictate payments, so we have great financial constraints,”

and another participant added, “I think we need a better health care system, a national health care.”

**Learning stage: action projects.** The development of an action project was the final learning stage for the intervention (Freire, 2016). These critical action projects were developed after the evaluation of the individual, organizational, institutional, and governmental impacts were weighed. The purpose of the action projects was to address the moral distress in nursing that requires input from individuals, institutions, and sometimes the public and governmental agencies. In Table 7, I display Group 1’s Action Project using the template tool.

<table>
<thead>
<tr>
<th>WHAT</th>
<th>Unit-Based Debriefing Workshops using different techniques such as journaling, mindful meditation, healing touch, yoga, and therapeutic group discussion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHY</td>
<td>To decrease emotional distress; to accommodate varied coping strategies; to target specific emotionally or morally distressing situations; to be proactive instead of reactive.</td>
</tr>
<tr>
<td>WHEN</td>
<td>Monthly</td>
</tr>
<tr>
<td>WHERE</td>
<td>A casual, safe space on or off the unit</td>
</tr>
<tr>
<td>HOW</td>
<td>Unit groups leaders to organize with nursing, chaplaincy, social work, and others who can provide said experiences.</td>
</tr>
</tbody>
</table>

In the discussion of Group 1’s Action Project exercise, one nurse from Group 1 stated, “our project is more like therapy for nurses. It’s unit-based exercises with nurses supporting one another.” This nurse added, “There could be a writing workshop, a faith-based workshop, a yoga class, a hiking class, because, not everyone copes in the same way.”
A participant outside of Group 1 noted, “This kind of thing shows that you are not alone, like there are people that you can do these things with.” Another member outside of Group 1 interjected, “One resource that we have, which I love, is that our chaplain is there for the staff.” She added, “I utilized him when I was new to critical care and saw lots of things I hadn’t been exposed to, and I kind of questioned whether or not this was the right choice for me.” Going on, she finished, “all I want to say is that “It's [interacting with the chaplain] been tremendously helpful for me.”

To review, during Session Three: Critical Action, the large group was led by a guide in the discussion and review of the journal article published by Fletcher (2006). This article introduced the concept of self-awareness and that it can be achieved through reflection as a strategy to break the cycle of oppression and initiate changes in the structures that oppress nurses. Next, each small group was guided through the learning stage of “strategy building, planning, resource-acquisition,” followed by the final exercise—an action project. A schematic depicts the outcomes of each group’s movement of the Freirean process across three sessions (see Figure 7).
Aim 3: Post-Intervention Interviews

A third data source for Aim 3 was the post-intervention interviews. The purpose of these questions was to evaluate the impact of the intervention on the nurses’ sense of personal and group empowerment. Below are summarized responses from 13 interviews. As presented in Table 8 selected quotes from the post intervention interviews question exemplifying the feelings and viewpoints of the participants and a summary from each question are presented.

<table>
<thead>
<tr>
<th>Question</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What was your overall impression of this intervention?</td>
<td>“I loved it, I felt like it was very healing, almost like a form of therapy.” Participant B &quot;So now, I look back and think about our discussions and when I’m at work and think how I can change things.” Participant A &quot;So, it really helped a lot because sometimes you do feel like you’re alone, like you’re...&quot;</td>
</tr>
</tbody>
</table>

Table 8

Post intervention interview, Empowerment Questions-1-14 questions, Quotes, and Summaries
the only one that feels this way.”
“I think this gave us some tools that we can take back to help in our work environment.” Participant M
“Helps us maybe recognize some signs that another nurse might not recognize that they’re actually going through moral distress.” Participant G
“This helped open the doors for me to see this does have a name.” Participant H
“I thought it was excellent and it lets me know I’m not alone.” Participant L
“I thought that I could really take things away from this.” Participant C
“I actually really liked it, and how we did the action plan on the last day.” Participant F
“Now I can look back and think about our discussions and think about how I can make it better.” Participant J
“I thought it was very, very good - it brings a lot of awareness about this topic.” Participant E
“I really liked it, I was glad I was not the only one feeling that way.” Participant D
“I thought it was a bid eye-opener for me, I didn't realize how much of a problem this is.” Participant I

**Summary**

Overall, the participants’ responses indicate they were pleased with the overall program. Several members underscored that it was a relief to realize they were not alone and that they were part of a group who shared the same struggles. This again coincides with what Freire referred to suffering in silence, where the nurses had been feeling negative and passive about themselves (Freire, 1995). The purpose of problem posing education is the recognition of shared group experiences that are based on personal experiences. The participants thought of ways to take the tools obtained from the intervention and apply them to make significant changes. This indicates learning from the problem-posing education because its goal is to produce social cohesion and mutual concern for change. Their learned social togetherness was revealed through their display of concern on the ways they can engage and help other nurses who they thought might be struggling. One person described it as a healing experience. According to Wallerstein and Auerbach (2004), part of promoting critical dialogue is helping participants create opportunities for healing and growth.

**Question**

2. Can you describe the most helpful thing that you learned in this intervention?

**Quotes**

“That you know as a nurse there are things we experience that no other profession experiences and it’s important for us to stick together, cause a lot of times we are not so much for each other, we’re against each other and that’s not the way to be.”
Participant A

“When these things are happening, they’re not happening to just me, but to everyone.”
Participant H

“If you break them down to like the issues, who had the power, what are the strategies for the future.”
Participant G

“I’ve gone to other seminars on moral distress and compassion fatigue, but this one taught us to apply system-wide plans to help things get better.”
Participant K

“When these things are happening, they’re not happening to just me, but to everyone.”
Participant I
“The last session where we came up with a plan and found how to do something about it.” Participant L

“The last session where we came up with a plan and found how to do something about it.” Participant L

“Hearing about all of the nurses, especially from the ICU that they are going through some of the same things.” Participant B

“I felt that I could really relate to this study, I felt that I could really take things away from this.” Participant C

“I think completing the action plan.” Participant F

“Being able to have the tools to use and look at the situation differently.” Participant J

“That if you can recognize moral distress in other nurses that you may be able to help them.” Participant E

“I would say that learning I am not alone in feeling this way.” Participant D

Summary

The realization that they needed to stick together instead of fighting with each other is consistent with the notion that liberation from oppression must come from within the oppressed group itself (Freire, 1995). A comment from one participant was made about how they each had learned to apply system-wide changes to improve their situations at work. She admitted to having attended other seminars that covered the topic of moral distress but stated that she did not learn about the approach to implement changes in the system during such sessions. This mentality is perhaps the result of the problem-posing education, wherein opportunities were not created for participants to enable them to think of ways to help themselves and their communities (Wallerstein & Auerbach, 2004). And as one nurse commented, if you recognize it in other nurses, you may able to help them as well.

Question

3. Can you tell me how this intervention changed your understanding about the cause of moral distress?

Quotes

“The articles were to the point, in fact, I even went through and underlined items that I liked.” Participant A

“I felt like maybe I wasn’t a strong enough person to handle the job or those kinds of feelings come up and you realize well that’s not necessarily the case.” Participant G

“So I just opened my eyes to what it actually is. I thought it was am I feeling depressed, am I doing something wrong and realizing no, it’s actually real and it’s out there.” Participant I

“One of the most important things it did for me was put a language to what I was feeling.” Participant H

“I know helped me personally in a lot of areas in my work. I was feeling burnout, but I’m kind of going in with a different attitude.” Participant K

“I had like really internalized it. I take it home and I think about it for weeks or days, and if something similar comes up, then I tend to kind of feel it all over again, but stronger.” Participant M

“I came in having my own causes of moral distress, but it helped me understand it more” Participant L

“I always thought it was just me, that it was my personal problem, that it was just me doubling myself as a nurse.” Participant B

“That is like care that doesn't feel good when I am giving it.” Participant C
“I think I never really looked at it, I always thought that it was related to futile care.”
Participant F

“That it is communal and shared by a lot of nurses.” Participant J

“I didn't look at these feelings as moral distress, but now a lot of what you said made some sense.” Participant E

“I really didn’t know what moral distress was, so it really opened my eyes to it.”
Participant D

Summary

4. How would you describe the most surprising thing you learned during the intervention?

Quotes

“I thought that was very interesting that there were studies out regarding nurses as an oppressed group. I thought it was feeling depressed, am I doing something wrong and realizing–no.” Participant A

“I feel like this, this sort of program needs to be taught at a new grad level, because or a new job coming in level, because the nurse I talked with this morning who’s starting a new job, she’s feeling some of this.” Participant H

“I think that a lot of us unfortunately, like the oppressed group we think it’s the norm.” Participant I

“I didn’t realize that I could feel so empowered by it.” Participant F

“How more common this it is than uncommon.” Participant E

“That there is a solution, but it isn’t going to happen tomorrow, and that we don't have a voice.” Participant L

“I learned to recognize moral distress.” Participant B

“It showed us how widespread the problem is.” Participant C

“That I didn't realize that moral distress had been studied.” Participant J

“That it is real and that I am not alone.” Participant D

“I really didn't know much about it to be honest.” Participant G

Summary

Summary: One nurse expressed surprise on how much better she felt after the intervention, and that she thought it beneficial for nurses who are willing to talk about it. The participants felt empowered in their ability to recognize situations that cause moral distress and in the willingness to talk about it honestly and openly. Freirean (1995) education is based on the recognition of the causes of oppression and the willingness to transform it into something positive. The intervention helped the nurses come to the realization that they were an oppressed group, and that their lives could change for the better. The job of the guide is to enable them to examine their lives and the aspects they may have taken for granted, because oppressed people have been taught and conditioned to be passive and silent (Beck & Purcell, 2013). Through the critical dialogue that occurred in the intervention, participants were taught to rethink the ways in which they can create opportunities for healing and growth while helping themselves and their communities. In this case, the participants’ realization about how widespread the problem of moral distress was helped them foresee the potential benefits of a program to prevent moral distress for new graduates; in fact, one nurse had already seen this behavior in a new graduate with whom she works.

Question
5. How do you think what you have learned during the intervention will help you in the future?

Quotes
“I’d already been verbal as a patient advocate. Where this way, I can question it, and stop and say, you know, if you take a minute to talk to them, they don’t want this, and they don’t want that, and family doesn’t want this, and family doesn’t want that. Why are we doing what we’re doing?”
“Definitely the action plan hopefully could take something further.” Participant C
“I think having the confidence to know that nurses deserve better treatment, and they deserve to know that they can have power.” Participant I
“I think I might question the doctors more about whatever it might be at the time and we need to do something about this.”
“And I feel like that for me, I can, I can seek out other coping mechanisms beside myself. I actually have talked to some of the people on our unit about starting like a moral distress team.” Participant H
“I’ve always been one to speak up, but now I am now more apt to question what the plan is and ask what we are doing?” Participant L
“Recognizing when I have moral distress and knowing that I can talk to somebody.” Participant B
“I think the action plan will help me in the future.” Participant F
“I think having the confidence to know that nurses deserve better treatment, that they deserve to have the power.” Participant J
“I think it helps me to feel validated in my feelings, I was always feeling so bad, like I should have been doing something differently.” Participant E
“I think I might question the doctors more and get ethics committee involved a little sooner.” Participant D

Summary
Several nurses acknowledged that they will need to seek help if they are exposed to morally distressing situations. As Freire (1995) noted, freedom requires the oppressed to discard the image of the victim and replace it with independence and responsibility. The participants in this intervention were motivated to start thinking in concrete, personally familiar terms of the social root causes of problems, and how they could effect change. This is evidenced by the creation of a potential moral distress team, as noted above. Their other responses, such as the act of speaking up, the recognition that they have confidence and deserve better treatment, and the ability to take action and question the doctors, are all related to the process called “transformative knowledge” which the application of concrete action through critical reflection on knowledge is (Freire, 1995).

Question
6. Are there other life situations that you could apply what you have learned?

Quotes
“My husband is a cop and I think even talking to him about some of this stuff, I feel like has maybe even helped him a little bit.” Participant B
“Yes I think so. I think just even with your own interpersonal family relationships, friends, not just professionally, but outside of work too, I think it’s helpful to recognize the effect.” Participant H
“Yes, other relationships - who has the power? Why do they have the power? What can
we do about that? If we feel like we need a voice in that situation.” Participant I
“But even with other friends, other cliques, other girlfriends, I hate to say even in the
church, but you know there is a hierarchy, you know there that, that you kind of fall
under.” Participant M
“Well I have a unique family, with lots of mental issues, but I think with your family it
is different.” Participant L
“Could probably apply this to other stressful life situations I suppose.” Participant C
“I could probably apply this to other stressful life situations” Participant F
“Yes, like interpersonal relationships and stresses from that.” Participant J
“I think I can apply this with friendships and teaching.” Participant E
“That this is like another coping mechanism that can be used.” Participant D
“Yes this program got you thinking about a lot of different things, even outside of how
it applies to nursing.” Participant
Summary
Several respondents discussed approaching other problems, such as interpersonal
relationships, with the same step-by-step process as was used in this intervention to
determine who has the power and why, and what can be done to change the situation.
This ideology is related to conscientization and Freire’s belief in the equal dignity of all
human beings and including rights that include being treated with absolute dignity and
respect, the right to knowledge and culture, to criticize their situation and to act upon it
(Freire, 1995).

Question
7. Can you tell me if you feel empowered enough to carry out your action project?

Quotes
Summary
The participants reported feeling empowered enough to carry out their action projects.
They gave concrete examples of potential action projects, some of which have already
started by their bringing them to their respective unit councils and obtaining
management support. Some of the examples reflected the action projects that were
developed during the interviews for this intervention, while others were shared by
individuals during the post-intervention interviews. At the same time, participants said
that despite expected pushback from people they knew, they will nevertheless work to
move the project forward. This coincides with the fourth learning stages wherein the
details to moving the action project are considered and issues needing attention are put
into play (Freire, 2016). This shows consideration of the process called “Action-
Reflection,” which refers to the continual interaction of action (praxis) and reflection on
that action to determine what worked, what didn't work and what affects any subsequent
changes in the action based on the critical dialogue (Freire, 2016).

Question
8. What did you learn about yourself?
Quotes “You want to be empathetic, but you don’t want to take it so personally that you either get overwhelmed or you shut down or.” Participant F
“I learned to be more confident and speaking up for myself and other colleagues, if I’m being mistreated or if they’re being mistreated.” Participant M
“I’d say that I am more powerful than I gave myself credit for.” Participant E
“That I’m not alone in feeling these feelings and there’s nothing wrong with me. I’m not too sensitive. I just care about my job, my profession. I think that was the big eye opener. And the funny part is, I was like even since the last session I haven’t been having the bad dreams. The dreams have kind of like lightened up.” Participant M
“I think that I’ve learned that I can talk to my resources instead dealing with whatever the issue may be.”
“That I wasn't alone. Those ethical issues keep coming up, and I have kind of taken a backset to some of them.” Participant L
“How to recognize when I have moral distress.” Participant B
“I feel like I have more of a sense of camaraderie after this.” Participant C
“That is was okay for me to have these feelings.” Participant F
“I feel like I have learned in these situations that I might just shut down kind of feeling withdrawn.” Participant J
“That I am not alone and I need to take a step back at sometimes, and just relax.” Participant D
“That I am not alone in my feelings and that there is nothing wrong with me;” Participant H
“That I really care about what happens to my patients and I am passionate about nursing.” Participant I
“The important feeling is that I am not alone, like I said before.” Participant F
“That I am not losing my mind.” Participant B

Quotes “I’m surprised at the amount of burnout. Just in the last month, two people had already come to me and said “listen, how do you deal with this? I think I’m burned out?” Participant J
“I also think nurses in hospitals have really big hearts and they are very intelligent, but they aren’t able to use autonomy. We’re so used to being as subservient that I think some people start to even believe it.” Participant G
“It enforced the fact that like we need to support each other, like that one article mentioned it was lateral violence, …I guess I never really thought about that with nursing.” Participant L
“We are not respected enough. I think our skills, our knowledge is not valued as much as it should be from co-workers, patients, families.” Participant E
“That you have to take each patient as an individual and get your own reward from that.” Participant L
“I think that nurses in the hospital feel like the pressure is al on them, and that they don’t have an outlet really.” Participant B
“I think that a lot of nurses feel this way.” Participant C
“This reinforced the fact that we have to support each other.” Participant F
“The amount of lateral violence there is in the workplace, nurses do eat their young.” Participant J

146
“There are a lot of different styles of nurses and nursing.” Participant D
“We care passionately about people, and we are not taken care of a lot of the time.”
Participant D
“That everyone treats people and handles things in a different way.” Participant I

Summary

Question
9. What did you learn about nurses in the workplace?

Quotes
“I’m surprised at the amount of burnout. Just in the last month, two people had already come to me and said “listen, how do you deal with this? I think I’m burned out?” Participant J
“I also think nurses in hospitals have really big hearts and they are very intelligent, but they aren’t able to use autonomy. We’re so used to being as subservient that I think some people start to even believe it.” Participant G
“It enforced the fact that like we need to support each other, like that one article mentioned it was lateral violence, …I guess I never really thought about that with nursing.” Participant L
“We are not respected enough. I think our skills, our knowledge is not valued as much as it should be from co-workers, patients, families.” Participant E
“That you have to take each patient as an individual and get your own reward from that.” Participant L
“I think that nurses in the hospital feel like the pressure is al on them, and that they don’t have an outlet really.” Participant B
“I think that a lot of nurses feel this way.” Participant C
“This reinforced the fact that we have to support each other.” Participant F
“The amount of lateral violence there is in the workplace, nurses do eat their young.” Participant J
“There are a lot of different styles of nurses and nursing.” Participant D
“We care passionately about people, and we are not taken care of a lot of the time.” Participant D
“That everyone treats people and handles things in a different way.”

Summary

The respondents said they were surprised by the amount of burnout, horizontal violence, and moral distress that seemed to occur in hospitals. They learned to connect some of the behaviors of lateral violence and bullying, to the lack of power and oppression that they experience. Participants connected these generative themes of lateral violence and moral distress and how they both relate to lack of power and oppression (Freire, 2016). As noted by Beck and Purcell (2013), these generative themes empower the participants to see images that had been invisible to them before, thus creating new hope and dignity. This is the stage wherein critical understanding and personal awareness of the individual’s relationship to the issue begins, and an understanding that the issue is experienced communally (Beck & Purcell, 2013).

Question
10. Was the group dynamic helpful?

Quotes
“Yes, I thought it made it so much more relevant because everyone participated.”
Participant B
“There are some things where I thought, oh my gosh, like I never thought that, I would maybe share the same experience or felt the same way as someone.” Participant C
“And I think it was in small enough groups, you don’t feel embarrassed or like you don’t have a voice.” Participant D
“We did the small conversations but then we brought it to the group as a whole. Each person at each table has a different story to tell.” Participant E
“Yes, it was good, and I enjoyed that I didn’t know the people I was with.” Participant B
“Yes, because having the different feedback helps shed a different light on things.” Participant L
“I like getting to meet people from different hospitals.” Participant C
“Yes, I thought the four person dynamic was really good because we had the time to speak and share and prepare answers.” Participant F
“I think it was great, I think all of us felt comfortable sharing our stories” Participant J
“Yes, very much helpful.” Participant E
“Yes I did because you can think about it in many different way.” Participant D
“Yes it was a good size and I liked that I didn't know all of the people.” Participant H
“Yes, I really liked the group that I was in-I think we worked well together.” Participant I

Summary
All the participants reported that they liked the size of the groups because it was conducive to their openly sharing their feelings and thoughts, making it easy to talk to one another. Several participants reported that, even though they normally would not have wanted to participate in a group exercise, they felt safe doing so in this case. This reiterates the importance of the group process in problem-posing education, because this process relies on personal experience to produce social cohesion and mutual concern for change (Blackburn, 2000; Wallerstein & Auerbach, 2004). Also, according to Beck and Purcell (2013), the strength of the group dynamic lies in the understanding that the issue is experienced communally.

11. Are there any support systems that you will be using in the future?
Quotes
“Find a nurse friend. You need to make a nurse friend. I was like that, that’s really true, because your family doesn’t understand.” Participant M
“I would like to use the action project that we created- post-huddles or difficult case huddles.” Participant H
“If we did do like a moral distress thing on the unit, I would use that for sure.” Participant L
“I don’t know that management can do that. I feel like when management is in the mix sometimes you feel like you can’t openly share depending on the manager.” Participant K
“At this point, I think that I would feel most comfortable talking to my peers.” Participant B
“We have our Chaplain who is kind of a support system for us.” Participant C
“We can use our Chaplain.” Participant F
“My Chaplain, my Educator.” Participant E
“I think it is important to find a nurse friend who you can talk to about these things also.” Participant D  
“I think the Chaplain and some people at work.” Participant I  

**Summary**  
Finding a nurse friend was deemed important so they can share with someone who understands their situation and struggles. Unsurprisingly, several respondents did not feel safe having their manager as a support system, because the latter was not a source of support in the past. In addition to utilizing support systems that already exist, several nurses suggested trying to use the action projects they created. This is an effective display of the nurses’ wishes to change the conditions of the social injustice they faced that had led to their inequity (Freire, 1995).  

**Summary**  
12. Can you tell me how this intervention will help you decide how to handle any morally distressing situations different in the future?  

**Quotes**  
“Yes. I feel more comfortable calling for an ethics consult or questioning something.” Participant M  
“Just knowing that what I am feeling is not my fault – I will try to act in more independent.” Participant E  
“When I am a charge nurse, I could pull my team aside after the fact and say hey we need to discuss this further. We need to huddle about this.” Participant F  
“I think knowing that there is a reason that this happens helps me to sit back and think about it before I react.” Participant K  
“I think we should all be more comfortable being as advocate, and this has shown me that.” Participant L  
“As far as work goes, it would be helpful to know that other people are feeling the same way.” Participant B.  
“Knowing that other people are going through it as well is really makes it less stressful.” Participant C  
“That what I am experiencing is moral distress, just understanding that helps a lot.” Participant E  
“I might try to be more assertive and push things a little farther.” Participant D  
“Just knowing what I am feeling will help me not crumble so much in the situation.” Participant H  
“I don't know but since I have had this information, my bad dreams have gone away.” Participant I  

**Quotes**  
**Summary**  
**Question**  
13. Do you feel that you do have power within the organization? If no, why do you think that nurses may not perceive that they actually have power?  

**Quotes**  
“Yes, but it’s a very superficial thing. I think um, even sometimes condescending to think that this is what’s going to make people happy and it’s not. And it’s not fixing the real issue.” Participant B  
“I really don’t think I have power over anything, because I always have to ask
permission to do anything to help the patient, you know. So, to me, you know, that’s you
don’t have power. But I just feel we set a lot of limitations.” Participant E
“I feel like I have personal power but not a powerful position as far as making strategic
decisions.” Participant M
“I have a voice, but I don’t have power. So, they can hear me, but people don’t listen.”
Participant A
“There is a hierarchy for sure, but the issue becomes when it is unsafe for patient care. I
will go toe-to-toe very respectfully. But, if I don’t feel comfortable with what’s going
on, I keep climbing that hierarchy until I get what I want.” Participant E
“To a point, but there is a limit. You have to become comfortable with it. I’m not really
comfortable with it but I am more brazen.” Participant L
“Not when it comes to higher management.” Participant B
“Recently I got to work evaluate some residents at work and they took our feedback so
that felt good.” Participant C
“Sometimes, I feel like I have power and other times–no–I want to get things fixed but I
just can’t.” Participant J
“Slightly yes, mostly no.” Participant E
“Overall, not really”. Participant D
“If I had to generalize I would say no.” Participant H
“We have perceived power, but not actual power.” Participant I

Summary
They felt a sense of personal power. As one participant said, “I feel like I have personal
power but not a powerful position as far as making strategic decisions.” However, they
have but a very low sense of structural power. This was evident by this nurse’s thoughts,
wherein she lamented, “they can hear me, but people don’t listen.” A different stance
was taken in several other interviews, with one respondent saying, “I think that we at
least are empowered to have the voice and then to take the steps needed to achieve what
we’re asking for.” One nurse in particular expressed what is a considered morally
courageous stance (Corley, 2002), noting, “there is a hierarchy for sure, but the issue
becomes when it is unsafe for patient care. I will go toe-to-toe very respectfully. But, if I
don’t feel comfortable with what’s going on, I keep climbing that hierarchy until I get
what I want.” These opinions are not surprising, considering that lack of empowerment
was shown to be a theme in many of these nurse's moral distress stories.

Question
14. Do you think that there is a difference between real power and perceived power?

Quotes
“The nurse’s definitely advocating and trying to do her job. Yeah. I would say we do
have perceived power, but not real power because I feel like when it comes down to it
we’re not really heard.” Participant B
“I think that I have some personal power – so I perceive that I have some power but
from the organization – not so much.” Participant K
“I have a hard time answering that, because so many hospitals are so pro-nurse on the
outside, but then when it comes to the nitty-gritty, you don’t really feel that. I think the
projected image that we love our nurses and then once you get in, the question is-do you
though?” Participant K
“It’s that dichotomy where you have so much responsibility, but you also are looked on
as something like, you know, not, not important or not, maybe not as professionals.”
Participant E
“I think so. Because if you don’t perceive that you have any power, when you do have the situation where do you have real power, I think you’re not going to take that.”
Participant C
“Absolutely, because we are a suppressed group. We come in suppressed and have to grow or don't grow.” Participant L
“Well, I think that nurse do have a lot of autonomy, but I do not think that they are really that respected.” Participant J
“Perceived power, because we are not able to do a lot of the things that people think we should.” Participant E
“Sometimes you perceive that you don't have power when you really do.” Participant E

Summary
Nurses in the study made the distinction regarding what they had thought was perceived power versus real power. The participants mainly felt they had perceived power, but not real power. One nurse noted a self-fulfilling cycle in this power arrangement, “Because if you don’t perceive that you have any power, when you do have the situation where do you have real power, I think you’re not going to take that.” This thought is consistent with those who are so oppressed, that it has been engrained in them to shy away from power, even when the opportunity for power presents itself (Freire, 1995). The power that nurses recognized in themselves was power on a personal level; however, on an organizational level, it did not exist. Commenting on this, a nurse said, “I perceive that I have some power, but from the organization, not so much.” Thus, this comment is in harmony with Michel Foucault’s notion that power is not a quality of an institution, but a product of the relationships in it (Foucault, 1977; Sadan, 1997/2004).

In summary, the participants were pleased with the overall flow and information from the program. The collective group learned about the connection between oppression and moral distress and the significance of the of moral distress in nursing. They discussed their perceived lack of organizational power but realized their power on a personal and group level. With their increased perception of personal and group power, they felt confident in pursuing their action projects. This reiterates the strength of the group dynamic in that is lies in the understanding that the issue is experienced communally (Beck & Purcell, 2013).
Quantitative Data Analysis

In the following section, the quantitative data for two aims. The first is Aim 2, feasibility and acceptability and the second Aim 3, impact of a conscientization intervention will be discussed. In addition to these two aims, quantitative data regarding the effect of the intervention will be considered as well.

Aim 2: Feasibility and Acceptability

The quantitative analysis for implementation, a criterion of feasibility and acceptability that indicates the extent, likelihood, and manner in which an intervention can be fully implemented as planned and proposed, was by recruitment and retention rates as suggested by Bowen et al. (2009) and Tinkle-Degnen (2013). The duration for total recruitment of 13 participants was two months. Recruitment rates for the first month were seven participants of 16 candidates; for the second month five additional eligible candidates were located through snowball sampling. The total recruitment was 21 potential eligible candidates yielded a total of 13 to participate. As mentioned previously, retention was 100%; however, as described in the procedures for the intervention in Chapter 3, full participation was not achieved. Table 9 depicts the attendance of the by participant code.

Table 9

Attendance Roster

<table>
<thead>
<tr>
<th>Session One</th>
<th>Session Two</th>
<th>Session Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Code Attended</td>
<td>Participant Code Attended</td>
<td>Participant Code Attended</td>
</tr>
</tbody>
</table>
Spearman’s rank correlation coefficient tests did not show any correlation between the number of sessions attended (two versus three) and any other variable including MDS-R, PES, or CWEQ-II scores.

**Aim 3: Impact of a conscientization intervention**

As shown in Table 10, MDS-R scores corresponded with “medium” mean levels of moral distress; “low-medium” frequency levels of moral distress; and “high” intensity levels of moral distress. Mean PES scores corresponded to “high” level of psychological empowerment, and mean CWEQ-II scores corresponded to “high” mean level of structural empowerment.

Table 10

*Mean Scores for Pre-and Post-MDS-R Frequency and Intensity Level, PES, CWEQ-II (N=13)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mínimo</th>
<th>Maximum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre MDS Total</td>
<td>76</td>
<td>220</td>
<td>132</td>
</tr>
<tr>
<td>Post MDS Total</td>
<td>41</td>
<td>214</td>
<td>111</td>
</tr>
<tr>
<td>Pre- MDS Frequency</td>
<td>21</td>
<td>54</td>
<td>38</td>
</tr>
<tr>
<td>Post MDS Frequency</td>
<td>11</td>
<td>55</td>
<td>34</td>
</tr>
<tr>
<td>Pre MDS Intensity</td>
<td>47</td>
<td>83</td>
<td>65</td>
</tr>
<tr>
<td>Post MDS Intensity</td>
<td>57</td>
<td>86</td>
<td>72</td>
</tr>
<tr>
<td>Pre PES Total</td>
<td>51</td>
<td>68</td>
<td>60</td>
</tr>
<tr>
<td>Post PES Total</td>
<td>56</td>
<td>70</td>
<td>61</td>
</tr>
<tr>
<td>Pre PES Meaning</td>
<td>11</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Post PES Meaning</td>
<td>11</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Pre CWEQ-II Total</td>
<td>57</td>
<td>83</td>
<td>72</td>
</tr>
<tr>
<td>Post CWEQ-II Total</td>
<td>52</td>
<td>85</td>
<td>70</td>
</tr>
</tbody>
</table>

Note. Ranges for MDS-R Total = 0-83 (non-slight), 84-167 (medium), 168-252 (moderate), 253-336 (severe); MDS- Frequency and Intensity 0-27 (low), 28-56 (medium), 57-84 (high); PES 12-35 (low), 36-60 (medium), 61-84 (high); CWEQ-II 10-33 (low), 34-62 (medium), 63-95 (high).
The results from five individual items from the pre-intervention MDS-R scale were evaluated individually because of their congruency with prominent themes that were uncovered in the moral distress stories. These themes were futility of care, family issues in futility of care, and prolongation of suffering through use of extraordinary means.

As seen in Tables 11 and 12, the first two items chosen were (a) continuing life support...insistence of the family (MDS-R Q3) and (b) initiating life extending treatments…prolong death (MDS-R Q4). Regarding frequency of occurrence, these two items were rated as frequent or very frequent by 77% and 69% of the nurses, respectively. Regarding intensity of the event, these two items were rated on a level of very much or a great extent by 100% and 84% of the nurses, respectively. These two clinical situations occur at frequent rate and are associated with moral distress at an intense level.

Table 11

*Pre-intervention MDS-R Q3 Frequency and Intensity “Family wishes continue life support I believe not best interest for the patient” (N=13)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Rare</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Frequently</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Slight</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Medium</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Very much</td>
<td>9</td>
<td>69.2</td>
</tr>
<tr>
<td>Great extent</td>
<td>4</td>
<td>30.8</td>
</tr>
</tbody>
</table>
As seen in Tables 13–15, the nurses reported on three clinical situations captured by the items (a) carry out MD orders...unnecessary tests and treatments (MDS-R Q 6), (b) participate in care of ventilator...no one will withdraw (MDS-R Q 7), (c) follow family wishes...fear of lawsuit (MDS-R Q 16). Regarding frequency of occurrence, these three items were rated as a frequently or very frequently occurring event by 46.2%, 69.3 %, and 38.5% of the nurses, respectively. Regarding intensity, when these situations did occur, the intensity of the moral distress was rated on a level of very much or a great extent by 69.2%, 92.3%, and 92.4% of the nurses, respectively. Although these three items do not happen as often, when they do, the nurses suffer moral distress at an intense level.

Table 12

*Pre-intervention MDS-RS Q4 Frequency and Intensity “Initiate extensive life-saving actions I think only prolong death” (N=13)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Rare</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Frequently</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>7</td>
<td>53.8</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Slight</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Medium</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Very much</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Great extent</td>
<td>7</td>
<td>53.8</td>
</tr>
</tbody>
</table>

Table 13

*Pre-intervention MDS-R Q6- Frequency and Intensity “Carry out MD Orders I Consider to be Unnecessary Tests and Treatments” (N=13)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Rare</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Frequently</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>7</td>
<td>53.8</td>
</tr>
</tbody>
</table>
### Table 14

Pre-intervention MDS-R Q7 Frequency and Intensity “Continue to Participate in Care for Hopelessly Ill Sustained on Ventilator No One Will Make Decision to Withdraw Care(N=13)

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Rare</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Frequently</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Slight</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Medium</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Very Much</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Great Extent</td>
<td>7</td>
<td>53.8</td>
</tr>
</tbody>
</table>

### Table 15

Pre-intervention MDS-R Q 16 Frequency and Intensity “Follow Family Wishes for Pt. Care When I do not Agree With Them but Do So For Fear of Lawsuit”(N=13)
<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Rare</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Sometime</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Frequently</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Slight</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Medium</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Very Much</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>Great Extent</td>
<td>6</td>
<td>46.2</td>
</tr>
</tbody>
</table>

The Psychological Empowerment Scale (PES) measured the perceived level of psychological empowerment. The scoring on six specific items from the pre-intervention PES was evaluated individually because of the compatibility with responses about personal empowerment revealed during the post-intervention interviews. Tables 16-21 display the data on individual items addressing how nurses perceived their level of psychological power in the workplace. When asked about confidence in their ability to do their job and how important work was, 92.3% reported they had that confidence, and 84.7% reported that their work was important to them. When asked about autonomy to do the job, and impact and control of what happened at work, 54%, reported that they had autonomy to do the job. Only 7.7% reported they had great control over what happened in their department. When asked about opportunities for independence and freedom, only 38% responded in a positive manner.
Table 16

*Pre-intervention PES “Confidence Ability To Do Job” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>Very strongly agree</td>
<td>3</td>
<td>23.1</td>
</tr>
</tbody>
</table>

Table 17

*Pre-intervention PES “Work Important To Me” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Very strongly agree</td>
<td>9</td>
<td>69.2</td>
</tr>
</tbody>
</table>

Table 18

*Pre-intervention PES “Autonomy To Do the Job” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Neutral</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Agree</td>
<td>6</td>
<td>46.2</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Very strongly agree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Table 19

*Pre-intervention PES “Impact on What Happens in the Department is Large” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Disagree</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Very Strongly Agree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 20

*Pre-intervention PES “Great control of What Happens In My Department” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Very Strongly Agree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 21

*Pre-intervention PES “Opportunity for Independence and Freedom” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Strongly</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Very Strongly Agree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
The CWEQ-II measured the perceived level of structural empowerment in the workplace. In other words, how participants perceived their access to those in power in relation to getting opportunities, getting information, getting support, and getting resources. The scoring from six specific items from the pre-intervention CWEQ-II was evaluated independently because of compatibility with responses about organizational empowerment revealed during the post-intervention interviews. Tables 22-27 displays the data from individual items indicating how nurses viewed their structural empowerment in their workplace. For the first two, access to information about current state of the hospital and access to information about goals of top management, only 7.7% and 7% responded that they had access a lot of the time. The next three, regarding access for getting supportive advice, access for supportive comments for improvement, and visibility of their work, only 15.4% and 7.7% perceived that they had access a lot, while no one (0%) perceived that their work had a lot of visibility. Finally, only 31% of the nurses reported that their work environment was empowering overall.

Table 22

*Pre-intervention CWEQ-II “Access to Info on Current State of Hospital” (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>None-Some</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Some</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Some-A Lot</td>
<td>7</td>
<td>53.8</td>
</tr>
<tr>
<td>A lot</td>
<td>1</td>
<td>7.7</td>
</tr>
</tbody>
</table>
**Table 23**

Pre-intervention-CWEQ-II “Access to Info on Goals of Top Management” (N=13)

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>None-Some</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Some</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Some-A lot</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>A lot</td>
<td>1</td>
<td>7.0</td>
</tr>
</tbody>
</table>

**Table 24**

Pre-intervention-CWEQ-II “Access to Support Helpful Problem-Solving Advice” (N=13)

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>None-some</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>Some</td>
<td>7</td>
<td>53.8</td>
</tr>
<tr>
<td>Some a lot</td>
<td>1</td>
<td>7.7</td>
</tr>
<tr>
<td>A lot</td>
<td>2</td>
<td>15.4</td>
</tr>
</tbody>
</table>

**Table 25**

Pre-intervention CWEQ-II Access to Support Comments for Things to Improve (N=13)

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>None-Some</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Some</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Some a lot</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>A lot</td>
<td>1</td>
<td>7.7</td>
</tr>
</tbody>
</table>
Table 26

*Pre-intervention CWEQ-II=Amount of Visibility of My Work-Related Activities (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>None-some</td>
<td>3</td>
<td>23.1</td>
</tr>
<tr>
<td>Some</td>
<td>8</td>
<td>61.5</td>
</tr>
<tr>
<td>Some -A lot</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>A lot</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 27

*Pre-intervention CWEQ-II= Overall Workplace Empowering Environment (N=13)*

<table>
<thead>
<tr>
<th>Rating</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>15.4</td>
</tr>
<tr>
<td>Neutral</td>
<td>7</td>
<td>53.8</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Effect of Intervention**

Related-Samples Wilcoxon Signed Rank Test revealed significantly lower total MDS-R mean scores ($p = .006$), and MDS-R frequency mean scores, ($p= .034$), and significantly higher MDS-R intensity mean scores, ($p = .001$) after the intervention, as seen in Tables 28- 30. Cohen’s $d_z$ was used to calculate effect size using the following scale (a).20 as a small effect size, (b) .50 as a medium effect size, and (c) .80 as a large effect size (Sullivan & Feinn, 2012). Cronbach’s alpha was used to measure internal consistency, with an alpha greater than .80 is considered good, (Cortina, 1993). The mean MDS-R total scores
had a medium effect size (.48), a high Cronbach’s alpha of (.95), 95% [94.84,148.45]. The
mean MDS-R frequency scores had a low-medium effect size (.40), a high Cronbach’s alpha
(.91), and 95% [28.95,42.77]. Finally, the mean MDS-R intensity scores had a medium-high
effect size (.65), a high Cronbach’s alpha of (.89), and 95% [62.8,74.82].

Table 28

*Pre and Post Mean Moral Distress Scores Hypothesis Test Summary*

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre MDS Total and Post MDS total equals 0</td>
<td>Related samples Wilcoxon Signed rank Test</td>
<td>0.006</td>
<td>Reject the Null hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05

Table 29

*Pre and Post Mean Moral Distress Frequency Scores Hypothesis Test Summary*

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre MDS-Total Frequency and Post MDS Total Frequency equals 0</td>
<td>Related samples Wilcoxon Signed rank Test</td>
<td>0.034</td>
<td>Reject the Null hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05

Table 30

*Pre and Post Moral Distress Intensity Scores Hypothesis Test Summary*

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre MDS Total Intensity Post-MDS Total Intensity equals 0</td>
<td>Related samples Wilcoxon Signed rank Test</td>
<td>0.001</td>
<td>Reject the Null hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05
As seen in Tables 31-33, there were no significant differences in the mean PES scores or mean CWEQ-11 scores post intervention. The mean PES had a low effect size (.35), a high Cronbach alpha of (.80), 95% [57.82,63.32]. The mean CWEQ-II also had a low effect size (20), a medium Cronbach alpha (.63), 95% [65.0,76.1]. There was one exception in the PES scale, that being the sub-dimension component called “meaning.” The three questions from the “meaning” subdimension are (a) My job activities are personally meaningful to me, (b) The work that I do is meaningful to me, (c) The work I do is important to me. This score showed a significant increase post intervention ($p = .046$), with a medium effect size (.50) with a high Cronbach alpha (.82), 95% [13.1,15.0].

Table 31

Pre and Post Mean PES Mean Hypothesis Test Summary

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre-PES Total and</td>
<td>Related samples Wilcoxon</td>
<td>0.073</td>
<td>Retain the Null</td>
</tr>
<tr>
<td>Post-PES Total equals 0</td>
<td>Signed rank Test</td>
<td></td>
<td>hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05

Table 32

Pre and Post PES Meaning Sub Dimension Hypothesis Test Summary

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre-PES mean and</td>
<td>Related samples Wilcoxon</td>
<td>0.046</td>
<td>Reject the Null</td>
</tr>
<tr>
<td>Post-PES mean equals 0</td>
<td>Signed rank Test</td>
<td></td>
<td>hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05
Table 3

*Pre and Post mean CWEQ-II Mean Hypothesis Test Summary,*

<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The median of differences between Pre CWEQ-II Total Levels Post CWEQ-II Total Levels equals 0</td>
<td>Related samples Wilcoxon Signed rank Test</td>
<td>0.623</td>
<td>Retain the Null hypothesis</td>
</tr>
</tbody>
</table>

Note. Significance Level is .05

**Convergence of Data**

Convergence is achieved when findings from both the qualitative and quantitative analysis are brought together for comparison and contrast (Creswell & Plano Clark, 2011a). In this study, the convergence of qualitative and quantitative data also had components of a transformative design as described by Creswell and Plano Clark (2011a), because the Freirean method was used to help address injustices and empower marginalized groups— in this case, nurses who suffered moral distress. Below, I present the convergence data results for Aim 2 and Aim 3.

For Aim 2– feasibility and acceptability—demographic data, recruitment and retention rates, and correlational data converged with responses from the post-intervention interviews. In evaluating demographic data compared to responses on post intervention interview questions, it indicated that all participants, regardless of age, race, and so on, reported the intervention as both acceptable and practical to implement. The recruitment and retention strategies were successful, as evidenced by the fact that 100% of the participants were recruited and no one was lost to attrition. This data converged with the post-intervention interviews in that the participants who only attended two sessions felt they were able to catch up with the content and participate in the intervention in a meaningful way. As
stated by one nurse "I wish I could have come to the first day, but I able to catch up” and another “I think you did a good job of getting all of the people caught up, I mean the ones that weren’t there.” These comments converged with Spearman’s rank correlation that showed no correlation between the number of sessions attended (two versus three) and any other variable including the MDS-R, PES, or CWEQ-II scores.

For Aim 3— to determine sources of moral distress,—three individual questions from the MDS-R, in particular, exemplified the convergence between the MDS-R survey and the moral distress stories (a) MDS-R question 3 (MDS-R Q3), MDS-R question 4 (MDS-R Q4), and MDS-R question 6 (MDS-R Q6). For the first—MDS-R Q3 “family wishes continue life support I believe not best interest for the patient”—77% of the nurses reported this as occurring frequently or very frequently, and 100% of them reported this situation caused moral distress very much or to a great extent. This data point converged with prominent themes from the moral distress stories, including futile and aggressive care as illustrated through examples such as family not honoring patient wishes, family abandonment, and abuse.

The second example of convergence of qualitative and quantitative findings, MDS-R Q4 “initiate extensive life-saving actions I think only prolong death,” 69.2% of the nurses reported that this type of clinical situation occurred frequently or very frequently, and when it did occur 84.6 % of the nurses reported it caused moral distress very much or to a great extent. This data point also converged with noticeable themes from the moral distress stories such as increased suffering and prolonging life, exemplified through stories about continuation on a ventilator for an incurable pulmonary condition, and, aggressive treatment despite metastatic cancer. In the third—MDS-R Q6, “carry out MD orders I consider to be
unnecessary tests and treatments”—46% of the nurses reported this as a frequently or very frequently occurring clinical situation, and 69% reported this situation caused moral distress very much or a great extent. This data converged with multiple themes from the moral distress stories regarding carrying out treatments ordered by physicians, such as the theme “carrying out continued treatment without patient benefit or recovery.” Also, noteworthy, all three, MDS-R Q3, MDS-R Q4, MDS-R Q6 ranked “high” on both frequency and intensity scales, meaning that these situations happened frequently to nurses, and when they did happen, the intensity of moral distress was great.

There was also convergence between a number of individual items from the PES and CEWQ-II surveys and the post intervention interviews. For example, on the PES item that measured “nurses’ perception about their impact in the department where they work,” only 7.7% reported feeling a large impact on work. This low impact report converged with responses in the interview where the participants felt they had perceived power, but not real power. As one nurse said, “I really don’t think I have power over anything, because I always have to ask permission to do anything to help the patient.” Another PES item measured the nurses’ “perception of their level of control over what happens at work,” while only 7.7% of nurses reported felt they had any great control over what happened at work. As one nurse said, “So, to me, you know, we have some power, but I just feel we set a lot of limitations.”

Individual items from the CWEQ-II, survey measured nurses’ knowledge about the state of the hospital and knowledge about the goals of top management. For both items, only 7% of the participants perceived they had a lot knowledge about the state of the hospital or goals of top management. Responses from the interview questions reflected those same sentiments. One respondent revealed, “I feel like I have personal power but not a powerful
position as far as making strategic decision,” and another said “I have a voice, but I don’t have power. They can hear me, but people don’t listen.” Additionally, in an item inquiring about the percentage of time nurses got positive responses from leadership, only 7.7% perceived that it was a lot of the time.

For nurses’ perception of “their work’s visibility within the organization,” 0% of the nurses perceived that their work was visible in the organization a lot of the time. Responses from the interview questions echoed those sentiments, with one respondent saying “Hospitals are so pro-nurse on the outside, but you don’t really feel that. I think the projected image that we love our nurses and then once you get in, the question is: Do you though?” Finally, only 31% of the nurses reported that their overall work environment was empowering. This opinion is shared by one nurse: “Power in the organization? Yeah, but it’s a very superficial thing. I think they are sometimes condescending to think that this is what’s going to make people happy and it’s not, and it’s not fixing the real issue.”

Finally, for Aim 3, reflecting on the intervention’s impact on moral distress, the MDS-R scores for mean and frequencies were significantly lower post intervention, with the exception of intensity scores, which were higher post intervention. This data converged with outcomes from the intervention activities and results from the post-intervention interviews. During the phase of Critical Reflection, the participants acquired some understanding of the root causes for their moral distress, namely their subordinate positions in the hierarchy to (a) physicians, (b) families, and (c) organizations. The post-intervention interviews converged with this data; as an example one of the nurses stated, “I felt like maybe I wasn’t a strong enough person to handle the job or those kinds of feelings come up, and you realize that’s not necessarily the case.” Another nurse: “So I just opened my eyes to what it actually is. I
thought it was am I feeling depressed, am I doing something wrong and realizing no, it’s actually real and it’s out there.”

In evaluating the impact of the intervention on participants’ perceived feelings of empowerment, there were no significant increases in either the mean PES or CWEQ-II levels post intervention, with the exception of one PES sub dimension component of “meaning” which did show a significant increase. The data from the empowerment surveys diverged from the results of the participants’ movement through the second and third phases of the intervention, as well as the post intervention interviews. For example, during the second phase of the intervention, Critical Motivation, the participants, having learned about oppressed group behaviors in nursing, recognized that powerlessness was the cause of their morally distressing situations. An example from the groups’ work during the Critical Motivation phase was recognition that they were powerless following through on patient wishes and effecting change in the system(s) in which they worked. Post intervention interviews converged with that acknowledgment. As one nurse put it, “I think that a lot of us unfortunately [are] like the oppressed group, we think it’s the norm.” Additionally, another nurse noted, “If you break them down to the issues, who had the power, what are the strategies for the future.”

Finally, in the Critical Action phase, the participants having been educated with material about how to break the cycle of oppression and initiate changes in structures that oppress them, developed action projects such as Unit-Based workshops and Palliative Care Scoring Systems. The post intervention interviews converged with this data in that nurses reported feeling more empowered on a personal and group level after the intervention. Examples from the post intervention interview included one nurse who said, “I’d say that I
am more powerful than I gave myself credit for,” and another, “I learned to be more confident and speaking up for myself and other colleagues, if I’m being mistreated or if they’re being mistreated.”

In conclusion, convergence of the data showed that the intervention was feasible and acceptability. Convergence of data revealed the sources of moral distress as: futile care, aggressive care against patient wishes, and unsafe care. Thematic analysis of both content and structure of the moral distress stories revealed nurses felt a lack of empowerment and a lack of resolution in care of the patients. After the intervention, convergence of data revealed lower moral distress levels and increased feelings of personal and group empowerment, however, no increase in structural empowerment. In addition, there was divergence in quantitative and qualitative data measuring empowerment.
CHAPTER 5

DISCUSSION

Participants in the Study

In the current study, the participants had a mean age of 38 years, with a mean work experience of 15 years. These demographics were comparable to Corley et al. (2001) and Pauly et al. (2009) who reported mean ages of 41 and 44 years, and mean work experience of 13 and 11 years, respectively. There were two studies with a slightly younger and less experienced demographic with a reported mean age of 35 years (Leggett et al., 2013) and a mean work experience of 9 years (Pavlish et al., 2013). In the current study, there were no correlations between age, years of work and moral distress levels, a finding corroborated by several other studies (Cavaliere et al., 2010; Corley et al., 2001; Dyo, Kalowes, & Devries 2016, Ohnishi et al., 2010). Conversely, three studies, (Mobley et al., 2007; O’Connell, 2015; & Rice et al., 2008) did show positive correlations between age, years of work, and level of moral distress. This inconsistent finding indicates no sustainable relationship found between these three variables.

Regarding educational level, 23% of the nurses in the current study had an ADN, 62% had a BSN, and 15% had an MSN. Other studies (Dyo et al., 2016; Leggett et al., 2013; O’Connell 2015; Pavlish et al., 2013) showed similar findings with a majority of nurses having BSN degrees, followed by much smaller percentages of nurses with ADN and MSN degrees. This study showed no correlation between educational level and moral distress levels., an outcome upheld by a number of studies as well by (Cavaliere et al., 2010; Corley et al., 2001, Dyo et al., 2016 & McAndrew et al. (2011). Unlike these studies, Meltzer &

Relative to gender, all of the participants in the current study were female. On the other hand, there were a number of studies (Corley et al., 2001; Dyo et al., 2016; Leggett et al., 2013; O’Connell, 2016; Pauly et al., 2009, & Shorideh et al., 2012) that did report results of both male and female nurses. Since the nursing profession in the United States has a preponderance of females at 91% ([NCSBN], 2017) it is not surprising that studies demographics reflect those same ratios as seen with 92.8% female, and 7.2% male (Dyo et al., 2016), and 94.4% female, 5.6 % male (Pauly et al., 2009). There have been several studies with higher male nurse representation such as 67% female and 33% male (Leggett et al., 2013), 77% female and 23 % male O’Connell, 2016), and 68% female and 33% male (Shorideh et al., 2012). Only one of these studies (O’Connell, 2015) found a significant difference in moral distress levels based on gender, with female nurses suffering a significantly, ($p < .05$), higher level of moral distress than male nurses.

With respect to ethnicity, 100% of the participants in the current study identified as Caucasian. Other studies reported participants with a more varied ethnic base as in Corley et al., (2005) with 67% Caucasian, 21% African American, 3% Asian, 2% Hispanic, and 7% “other.” Dyo et al., (2016) with 65% Caucasian, 17% Asian, 8% Hispanic and 20% as “other,” as well as O’Connell, (2016) with 93% Caucasian, 3 % African American, 3% Hispanic, and 1% “other.” Two of these studies did report differences in moral distress intensity and levels based on ethnicity. Corley et al. (2005) discussed significantly, ($p = .01$), higher moral distress intensity in African American nurses, and Dyo et al. (2016) reported significantly higher, ($p = .01$), moral distress levels in Hispanic nurses. Contrary to these
findings, O’Connell (2016) did not find any significant differences in moral distress levels based on ethnicity.

All of the participants in the current study self-identified as having recently experienced moral distress. To the best of my knowledge, there are no other studies where the participants were recruited with that criteria.

**Feasibility and Acceptability**

I used three criteria from Bowen et al.’s (2009), framework which was developed to evaluate feasibility in intervention studies. Bowen’s three criteria (a) acceptability, (b) practicality, and (c) implementation were appropriate for the current study because they evaluated important measures to help build on this pilot study for future research. According to Bowen et al. (2009), acceptability is the evaluation of the intended individual recipients’ reactions to the intervention; practicality explores the extent to which an intervention can be delivered with resources, time, commitment; and implementation appraises the extent, likelihood, and way an intervention can be fully implemented as planned and proposed (Bowen et al., 2009; Tinkle-Degnen, 2013).

In the current study, sufficient acceptability was achieved when all the participants reported satisfaction with length of program, flow of information, and comfort with topics being discussed. In addition, the participants offered recommendations for future interventions. Pavlish et al. (2013), who conducted a moral distress pilot intervention, also evaluated acceptability through the use of questionnaires. As in the current study, the participants in Pavlish et al.’s (2013) study were satisfied with the length of program but made suggestions for improvements. In this study, adequate practicality was confirmed by participants describing the surroundings where the intervention occurred as comfortable and
private. There were no issues with the physical surroundings, and the responses were all positive. Respondents mentioned how appreciative they were that the sessions were conducted away from a hospital setting.

In the current study, implementation was successful in that the goal of recruiting 100% of sample was achieved, and no one dropped out of the study. Even though full participation by all 13 participants in all three consecutive sessions was not achieved, the participants were satisfied with the content and felt that they could participate in the intervention in a meaningful way. Kleinknecht-Dolf et al. (2014) had a less successful implementation when developing an instrument to measure moral distress in nurses in Switzerland. Their participants reported that the online registration process was complicated and time-consuming, resulting in a response rate of only 55% (Kleinknecht-Dolf et al., 2014).

Unlike other studies, I also evaluated feasibility and acceptability by examining demographic and correlational data along with results from the post-intervention questionnaires. This assessment showed that no demographic data corresponded to satisfaction with the intervention, and there was no correlation between the number of sessions attended (two versus three) and any other variable including MDS-R, PES, or CWEQ-II scores. In addition, the post intervention feasibility and acceptability interviews showed no difference in participant satisfaction in the program based on the number of sessions attended.

It should be noted that an extensive amount of time, commitment, and resources were used to implement this study. For the researcher, many hours were spent during the recruitment of participants, and personal resources were used in providing tools, food, and
reimbursement to the participants. The participants also were asked to donate 12-13 hours of their time, and often this required them to rearrange work schedules and obtain childcare.

**Components of Moral Distress Stories**

**Sources of Moral Distress**

In the current study, the data from the narrative analysis of the moral distress stories revealed that the four major clinical sources of moral distress were (a) futility of care, (b) prolongation of life, (c) unwanted aggressive treatment, and (d) witnessing unsafe care. Numerous other studies corroborate these findings (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015; Varcoe et al., 2012a) and name both futility of patient care and prolongation of life as the most common clinical source for the development of moral distress. Like this study, unwanted aggressive treatment has also been reported by various others (Dzeng et al., 2015; Houston et al., 2013; & Whitehead et al., 2015) as a major source in causing moral distress, along with the witnessing of unsafe care (Corley et al., 2005; Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015; Wilson et al., 2013). Unlike other studies, a theme of “lack of resolution” was uncovered as a source of moral distress in nursing.

**Response of Nurse**

In the present study, responses of the nurses reported as nightmares, headaches, frustration, detachment, guilt, remorse, and others, have been described broadly in the literature (Huffman & Rittenmeyer, 2012; Meltzer and Huckabay, 2004; Oh and Gastmans (2015). Furthermore, many reports have discussed the association between these nurse responses and the deep personal harm and long-lasting professional damage that can lead to burnout in nursing (Oh & Gastmans, 2015; Hamaideh, 2014 & de Veer et al., 2013),
**Power Dynamics**

Similar to moral distress research conducted over 30 years (Huffman & Rittenmeyer, 2012; Jameton, 1993; Oh & Gastmans, 2015; Wilkinson, 1987), the moral distress stories told in this study were interwoven with descriptions of power struggles occurring between nurses and patients, families, administration and physicians. This included anger vented on nurses from patients for providing unwanted and aggressive care as reported in other research (Huffman & Rittenmeyer, 2012; Laabs, 2011; Mobley et al., 2007; Varcoe et al., 2012a). In addition, as in this study, the notion of families’ unrealistic expectations and overriding patient wishes (Ganz et al., 2012), and bullying behavior by families have been supported by others (Huffman & Rittenmeyer, 2012). The lack of administrative support reported by the participants in the current study has been confirmed in other research (Ganz et al., 2012; Huffman & Rittenmeyer, 2012: Piers et al, 2012), as well as the findings that nurse work in an unethical work environment (Atabay et al., 2014; Browning, 2011; Pauly, 2009).

Like McAndrew et al. (2011), Hamric and Blacknall (2007), Huffman and Rittenmeyer, (2012), physicians in the current study subverted nurses and patient wishes, ignored requests for conversations with families, and displayed unethical behavior Comparable to Daiki, (2004) nurses in this study felt excluded from the decision making process, and like Huffman and Rittenmeyer, (2012), they felt fearful of repercussions they would suffer by raising concerns about unsafe care or ethical issues. Because of the aforementioned issues, the nurses in this study expressed frustration and exhaustion at their attempts to work through the patient and family dynamics, the organizational roadblocks, and the pushback by physicians merely to have their patient care circumstances end without
any positive resolution. Varcoe et al. (2012a) reported similar findings when she discussed the extraordinary efforts taken by nurses to resolve problems which never reached resolution or closure. In accordance with this expressed frustration, the structural analysis of the moral distress stories in this study revealed that the nurses’ stories ended without closure, a finding also described in Huffman and Rittenmeyer, (2012).

The evidence that unequal power imbalances prevalent in health care hierarchies contribute to moral distress were found in this study and others (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). These descriptions of interwoven power struggles, and the nurses’ frustrations draws attention to nurse’ relative low power status within health-care hierarchies. Nurses in the current study attempted to be moral agents and work through the established hierarchy power structures, but their lack of success is indicative of their relative low position within the health care hierarchy. This study was the first to consider the role that oppression played in the unequal power imbalance related to the development of moral distress in nursing. Because of this, this study was the first to develop and evaluate an intervention that was created and modeled on Freire’s (1995) problem-posing framework and pedagogy for identifying oppressive factors and promoting empowerment.

**Impact of Intervention-Taking Action to Change**

As hypothesized, the conscientization intervention helped to significantly decrease the mean total moral distress scores and mean moral distress frequency scores post intervention. This result is similar to Leggett et al. (2013) whose mixed method interventional study pilot study resulted in significantly lower moral distress scores post intervention as well. The current intervention was successful in lowering moral distress scores, in large part, because after sharing their moral distress stories in their groups,
participants wanted to find out why they were having negative feelings when trying to advocate for patients. This process resulted in a mutual concern for change that was based on the group members’ personal experience with moral distress.

As referenced by Beck and Purcell (2013), problem-posing in the current study began when the participants reflected on how moral distress was experienced by all of them as a group. As the groups decoded their moral distress stories, members identified themes associated with lack of power and how this lack of power was instrumental in causing their moral distress. In problem-posing education, themes of lack of power in the moral distress stories became apparent in areas where the nurses had not seen them before. This was empowering for the nurses because it created some hope and dignity, whereas, before the intervention, they were feeling confused and powerless (Freire, 1995).

After participants in the current study gained some knowledge about the role oppression played in their moral distress stories, and how they had been suffering in silence (Freire, 1995), they were able to evaluate their situations from a different perspective, one that allowed them to see the situation for what it is and act upon it (Freire, 1995). Nurses discovered ways to lead themselves out of oppression, and they developed action projects based on weighing what they thought would work and not work in achieving their goals. This was the beginning of what Freire (1995) called conscientization or “taking action against the oppressive elements of their reality” (Freire, 1995, p. 17). From the perspective of Freirean philosophy, the nurses in this study exercised their right to understand their culture including the inequities in it, and to take actions against those inequities (Freire, 1995). The action projects created by the nurses in this study were achievable, in fact,
several nurses planned to utilize them in their workplace. Develop of action projects is the unique contribution provided by the Freirean pedagogy.

It was also hypothesized that the conscientization intervention would help significantly decrease nurses’ moral distress intensity levels as well. Contrary to that hypothesis, the mean MDS-R intensity scores increased significantly post-intervention with both pre and post ranking in the high range. This finding of higher moral distress intensity scores versus mean or frequency scores is not new (Browning, 2013; Ganz et al., 2012; Piers et al., 2012; Silén et al., 2011). Since the intensity of moral distress measures the extent to which a person finds a situation distressing, perhaps the nurses felt more troubled after the intense examination of the oppressive components of the morally distressing situations that occurred during the intervention. As Montero (2007) discusses, conscientization can be an emotional journey where one recognizes the impact of choices and situations that have influenced one’s living conditions.

As hypothesized, increased feelings of personal and group empowerment were reported in the post intervention interviews. While the nurses did not feel they had official power within the organization of the hospital, participants did indicate that they strongly believed in the importance of the care they provided, and they displayed confidence in their ability to provide that care. They also implied that they felt they could have a meaningful impact on patient care by working together and working through the steps to make small system changes. The nurses attributed these feelings to being able to make some sense of what they were feeling, knowing they were not alone, learning the tools to help prevent moral distress from happening again, and gaining some knowledge and skill in developing action projects that they felt empowered to carry out. This group empowerment is a result of
the successful movement of each group through the intervention sessions of critical reflection, critical motivation, and critical action whereby there is group recognition of the oppressive forces causing moral distress and group creation of action projects to change those forces (Freire, 2016).

The increased feelings of empowerment expressed in post-intervention interviews was not borne out in the survey assessments. Contrary to the researcher’s hypothesis, neither the post intervention PES scores (measuring psychological empowerment) nor the CWEQ-II scores (measuring structural empowerment) were significantly higher post-intervention. This was similar to several nursing studies on ethics that measured empowerment (Browning, 2013; Ganz et al., 2012), where the nurses had an overall high level of psychological and structural empowerment, but there was no significant increase in these levels post-intervention. One sub dimension of the PES survey called “meaning” did increase significantly post intervention coinciding with the belief that the intervention helped improve the nurses’ perception of their personal and group power, but not the perception of their psychological and structural power at the workplace.

There are several possible explanations for the divergence between the quantitative and qualitative data surrounding perceived empowerment. First, the participants had already ranked themselves as having “high” overall levels of psychological and structural empowerment prior to the intervention, and it would have taken considerable shifts in their feelings to show significant improvement in the surveys across the board. Second, the small sample size limited the statistical power to accurately detect changes measured by the PES, and CWEQ-II tools. Third, these empowerment surveys measured a number of sub dimensional components of empowerment. For the PES these sub dimensions were (a)
meaning, (b) competence, (c) self-determination, and (d) perceived ability to impact the workplace (Spreitzer, 1995). Pertaining to the CWEQ-II the sub dimensions were (a) opportunity, (b) information, (c) support, (d) resources, formal and informal power for the CWEQ-II, (Laschinger et al., 2001).

The only empowerment measure that increased significantly post intervention was the “meaning” subdimension from the PES. This “meaning” sub dimension is characterized as the value of the work goal that is weighed in relation to an individual’s own ideals and standards (Spreitzer, 1995). This “meaning” sub dimension data coincides with the belief that the intervention helped improve the nurses’ perception of their personal and group power, but not their perception of their psychological and structural power in the workplace. I also suspect that there may have been too short a time period from pre and post measurement of empowerment, the nurses need to live with their new power an try it out to have a real change in perceived empowerment.

This divergence exemplifies the dichotomy of having feelings of personal power but not being able to use them because of the conditions that are present in organizational and structural environments that diminish the power of a social group–in this case–nurses. As one nurse remarked, “If you don’t perceive that you have any power, when you do have the situation where do you have real power, I think you’re not going to take that.” Perhaps a different way of asking the question about empowerment would have been more beneficial, for example, using a scale to ask much change in how you think about MD, oppression and empowerment?

Nurses in the study made a distinction regarding what they had thought was perceived power versus real power, feeling that they mainly had the former, not the latter.
One nurse noted a self-fulfilling cycle in this power arrangement, “Because if you don’t perceive that you have any power, when you do have the situation where do you have real power, I think you’re not going to take that.” This thought is consistent with those who are oppressed, in that it has been engrained in them to shy away from power, even when the opportunity for power presents itself (Freire, 1995). The power that nurses recognized in themselves was power from a personal and group level, not from an organizational level. Commenting on this, a nurse said, “I perceive that I have some power, but from the organization, not so much.” This comment is in harmony with Michel Foucault’s notion that power is not a quality of an institution, but a product of the relationships in it (Foucault, 1977; Sadan, 1997/2004).

Empowerment for nurses in part depends on their inner belief in the ability to be empowered, and an understanding that there is power in the care that nurses provide (Manojlovich, 2007). Despite these results, and because of the conditions that are present in organizational and structural environments that diminish the power of nurses along with their existing experiences of oppression and oppressed group behaviors (Cudd, 2006; Young, 1990), I suspect that it will take more than this intervention to significantly change how nurses truly perceive their psychological and structural workplace power. I suspect that there may have been too short a time period from pre and post measurement of empowerment and the nurses need to live with their new power and “try it out” to have a real change in perceived empowerment.

As previously mentioned, recent interventional research on moral distress in nursing has resulted in positive outcomes. Beumer (2008) increased nurses’ understanding of moral distress, Legget et al. (2011) saw significant decreases in moral distress levels post
intervention, and Pavlish et al. (2013) produced an effective early screening tool to prepare nurses to manage ethically challenging situations. Nonetheless, all of these studies revealed the powerlessness of the nurses’ capabilities or inclination to utilize their findings.

**Limitations**

The study has a number of limitations. First, since this was a pilot study, the small sample size limited the statistical power to accurately detect changes measured by the MDS-R, PES, and CWEQ-II tools. Post hoc power calculations determined that sample sizes of 31 for the MDS-R, 55 for the PES, and 157 for the CWEQ-II were needed to achieve significance levels of (.05) and a power of (80), and a CI of (.95). Second, the analysis of the qualitative data was performed by the researcher alone. Corroboration by one or more other researchers, also called a validity check (Lincoln & Guba, 1985), would have increased the trustworthiness of the interpretation by subjecting my interpretations to a peer review process (Lincoln & Guba, 1985).

The third limitation concerns the sample itself. The sample was homogeneous, with 100% of the sample consisting of Caucasian females from one geographic area. Since this study evaluated the experience of empowerment and oppression, the homogeneity of the sample might have produced responses that should not be extended to groups of other racial and gender identities. Based on the concept of intersectionality, there are social determinants such as racism, sexism, and classism that form intermingling systems of oppression based on the underlying power structures that produce imbalances (Green, Evans, & Subramanian, 2017). These systems shape the experiences of individuals and must be taken into consideration when evaluating empowerment and oppression. Given that this sample was homogeneous in relation to ethnicity and gender, the variability in moral distress
experiences previously describe on ethnicity (Corley, et al 2001; Dyo, et al 2016), and
gender (O’Connell, 2015) would not be found.

The fourth limitation is involving the measurement of the component of frequency of
moral distress post intervention on the MDS-R. Even though this study showed a
significantly ($p = .34$) lower level of moral distress frequency post intervention, the short
time frame of three weeks between the pre and post MDS-R may not be enough time to have
a change in frequency in moral distress. The fifth limitation concerns the challenges in the
implementation of the intervention. Due to illness and schedule changes, not all 13
participants attended all three sessions as anticipated. Adjustments were made in the
delivery of the intervention that may have had an impact on outcomes.

Finally, the last limitation concerns the short time frame of the intervention versus
the significant amount of time necessary to work through the process towards
conscientization. Working toward conscientization is a continual and cyclical process in
which one learns and relearns about oneself and one’s relationship to the world (Freire,
1995). In order to understand if the participants have moved forward with the cyclical
process, it will take longer than three weeks.

**Implications for Future Research**

The purpose of this pilot study was to test for feasibility and accessibility and to
evaluate the impact of a conscientization intervention on nurses who have suffered moral
distress. This study is the only moral distress study to test a conscientization educational
intervention and the only study to specifically recruit nurses who have recently experienced
symptoms of moral distress. Feasibility and acceptability of the intervention were confirmed,
but the implementation could be improved by having a longer recruitment period of perhaps
three months. The intervention was effective in helping nurses recognize that moral distress evolves from a lack of power due to oppression in the hospital hierarchy, develop the agency to do something about it, and engage in behaviors to draw attention to the difference in power and promote change through an action project.

There are several suggestions for future research. This study should be replicated using a larger and more racially and gender diverse sample of nurses. By diversifying the sample, a richer and more varied experience in power dynamics and oppression could be evaluated. The larger sample size, based on the sample power calculations, would improve the ability to detect effects of the intervention on moral distress levels, psychological empowerment and structural empowerment using the MDS-R, PES, and CWEQ-II scales. A possible strategy for replicating the study with a larger sample could be repeating the study in varied geographic areas of the U.S., or perhaps using international sample as well. Another option is that this study could be repeated after some refinement of the intervention, such as presenting the journal article for group discussion, as suggested by several of the participants, putting more detail in the action plans or assigning the participants to analyze their own story and “rewrite from an empowered stance.”

The current study was set up as a pilot to determine initial outcomes as well as feasibility and acceptability. The process of working toward conscientization is a continual process in which one learns and relearns about oneself and one’s relationship to the world (Freire, 1995). In order to understand if the participants have moved forward with the cyclical process, future research should incorporate evaluation of outcomes at later dates, perhaps three to six months post intervention to determine if they were able to actualize their action projects.
In addition, because this intervention requires an intense hands-on approach, numerous, small, multi-site interventions might be implemented and later evaluated as one group. Also due to the time investment from a participant’s standpoint, it might be useful to evaluate a two-session program, perhaps a two day retreat, versus a three-session program since there were no outcome differences between nurses that attended two or three sessions in this study. Finally, because this intervention requires specific skills, a large time commitment, resources, and administrative support for nurses to be away from the hospital, financial support through grants money is recommended.

**Implications for Practice**

In a recent executive summary on moral distress, nurse experts concluded that the incidence of moral distress is likely to increase based on increasing complexities in health care. (Rodney, 2017). With the incidence of moral distress likely to rise, and no proven treatment to prevent or remedy moral distress, it is time to introduce a novel method for evaluating and treating this problem. It is clear that uneven power dynamics in health care hierarchies are a large factor in causing of moral distress in nurses (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). Because nurses are an oppressed group (Roberts, 2000), it is important to understand and talk about oppression’s role in nursing’s development of moral distress.

By acknowledging and understanding the way oppression has influenced moral distress—through conscientization—nurses can achieve empowerment. The process of critical reflection, critical motivation, and critical action will give nurses the lifelong tools to help not only prevent moral distress from happening in the future but to teach and mentor others as well. Results from this study suggest that pursuing development and
implementation of conscientization interventions in hospital settings can make a difference. If moral distress is not addressed in a substantial way, nurses will continue to leave the profession to survive.

**Conclusions**

The purpose of this study was to develop, and pilot test an intervention with critical care nurses who have recently experienced moral distress. The study had three specific aims: (a) to design a brief, small-group intervention for moral distress based on Freire’s conscientization and Cudd’s concept of social oppression; (b) to test the feasibility and acceptability of the intervention with a small group of nurses who have recently experienced moral distress; and (c) to measure the impact of the intervention on moral distress and empowerment. I sought to answer the research question: “What is the impact of a conscientization intervention on nurses’ perceived sense of empowerment and their responses to clinical situations that create moral distress?”

The participants in this study were evaluated using a novel approach for understanding and treating moral distress in nurses. Using a collective of nurses who experienced moral distress communally, they participated in problem-posing education where collective dialogue is used to identify, motivate, and redefine their social identity and reclaim power. Results of the pilot study showed that the three-session educational intervention was feasible and acceptable, and that it significantly lowered levels of moral distress, and increased personal and group empowerment in nurses. These outcomes indicate that a conscientization intervention formulated around critical reflection, critical motivation, and critical action delivered in a small-group format with nurses is a feasible, acceptable,
and by the preliminary evaluation, a potentially effective way to reduce moral distress levels and begin to develop personal empowerment.
## Session One Tool – Information Gathering Form “Understanding Ourselves” Freire Institute

© 2016

<table>
<thead>
<tr>
<th>Name</th>
<th>Family and Background</th>
<th>Education</th>
<th>Work or Role</th>
<th>Involvement(s)</th>
<th>Sources of Information</th>
<th>View of Society</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Session One Tool “Understanding What Already Exists” Freire Institute © 2016

[Diagram showing the cycle of Culture, Power, and Resources]
### Appendix C

Session One Tool “Weighing Options” Freire Institute © 2016

<table>
<thead>
<tr>
<th>Makes Moral Distress Situation better</th>
<th>Makes Moral Distress Situation worse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D
Schematic Session One

All 12 participants = consent signed, demographic data form, MDS-R, CWEQ-II, and PES (20 minutes)

- Small group (3-4) - write components from tool “Understanding Ourselves” stories one at a time among the group (on large tablet paper (45 minutes)
- Small group (3-4) - write components from tool “Understanding Ourselves” stories at a time among the group (on large tablet paper (45 minutes)
- Small group (3-4) - write components from tool “Understanding Ourselves” stories one at a time among the group (on large tablet paper (45 minutes)
- Small group (3-4) - write components from tool “Understanding Ourselves” stories one at a time among the group (on large tablet paper (45 minutes)

All 12 participants view all stories (20 minutes)

- Small group (3-4) - write moral distress stories individually - post these on the wall (45 minutes)
- Small group (3-4) - write moral distress stories individually - post these on the wall (45 minutes)
- Small group (3-4) - write moral distress stories individually - post these on the wall (45 minutes)
- Small group (3-4) - write moral distress stories individually - post these on the wall (45 minutes)

Each small group does a presentation to the one large group for discussion (50 minutes)
Homework assigned
Appendix E

Session Two Tool “Understanding Where We Wish to Go” Freire Institute © 2016

**Culture**
Values, ideas, beliefs, faith, ideologies, prejudices, opinions, attitudes

**Power**
Decisions, rules, regulations, systems, procedures

**Resources**
Finance, staffing expertise

**Institution 2027**
Appendix-F

Schematic for Session Two

All 12 participants = discussion led by animateur regarding homework assignment of Matheson and Bobay article (60 minutes)

Small group (3-4)- write components from tool “Where We Wish to Go” among the group (on large tablet paper (45 minutes)

Small group (3-4)- write components from tool “Where We Wish to Go” a among the group (on large tablet paper (45 minutes)

Small group (3-4) write components from tool “Where We Wish to Go” among the group (on large tablet paper (45 minutes)

Small group (3-4)- write components from tool “Where We Wish to Go” the group (on large tablet paper (45 minutes)

Each small group does a presentation to the one large group for discussion (60 minutes)
Homework assigned Fletcher article
## Present Situation

<table>
<thead>
<tr>
<th></th>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>WHY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHERE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

Schematic Session Three

Group discussion led by animateur All 12 participants = review of article Fletcher 2007) (30 minutes)

Small group (3-4)- write components from tool “Strategy Building, Planning, Resource-Acquisition, Implementation on large tablet paper (45 minutes)

Small group (3-4)- Action Project Template (45 minutes)

Each small group does a presentation of their action Project to the large group for discussion (50 minutes)
Appendix J
Demographic Tool

Demographic Information  Participant Code ________________

1. Age
2. Sex
3. Years in nursing?
4. Highest degree earned?
5. Years in critical care nursing?
6. Kind of critical care unit?
7. Length of time since moral distress experience?
8. Is nursing administration supportive of interventions to help with ethical issues or moral distress? If yes, please give example
9. How long have you been a member of AACN?
10. Are you politically active in AACN? If so, in what?
11. Hospital bed size?
12. Ever participated in an ethics consult on patient?
13. Ever had any ethics education in end-of-life care?
14. Have you even had any education on moral distress? if so where?
Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select “0” (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: Frequency and Level of Disturbance.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Level of Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Very frequently</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.
2. Witness healthcare providers giving “false hope” to a patient or family.
3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.
4. Initiate extensive life-saving actions when I think they only prolong death.
5. Follow the family’s request not to discuss death with a dying patient who asks about dying.
6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.
9. Assist a physician who, in my opinion, is providing incompetent care.
10. Be required to care for patients I don’t feel qualified to care for.
11. Witness medical students perform painful procedures on patients solely to increase their skill.
<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Very frequently</th>
<th>None</th>
<th>Great extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Provide care that does not relieve the patient’s suffering because the physician fears that increasing the dose of pain medication will cause death.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Follow the physician’s request not to discuss the patient’s prognosis with the patient or family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Witness diminished patient care quality due to poor team communication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Ignore situations in which patients have not been given adequate information to insure informed consent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Watch patient care suffer because of a lack of provider continuity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Work with levels of nurse or other care provider staffing that I consider unsafe.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If there are other situations in which you have felt moral distress, please write them and score them here:

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I’ve never considered quitting or left a position

Yes, I considered quitting but did not leave

Yes, I left a position

Are you considering leaving your position now? Yes No

© 2010, Ann Baile Hamric
All Rights Reserved
Appendix L

Permission for MDS-R

Ann B Hamric <abhamric@vcu.edu>
Tue 3/24/2015 6:18 AM
To:
Bevan, Nancy A. (UMKC-Student);
Cc:
meg4u@Virginia.EDU;
Alison Crehore <acrehore@vcu.edu>
I am pleased to give you formal permission to use the MDS-R.
Best wishes,
Ann Hamric

Permission to use MDS-R tool for my dissertation research

Bevan, Nancy A. (UMKC-Student)
Mon 3/23/2015 4:20 PM
Thank you Dr. Hamric, I agree to your conditions and do plan on using the Adult version Thank you so much Regards Nancy Bevan

Ann B Hamric <abhamric@vcu.edu>
Sat 3/21/2015 2:59 PM
To:
Bevan, Nancy A. (UMKC-Student);
Cc:
meg4u@Virginia.EDU;
Alison Crehore <acrehore@vcu.edu>
To help protect your privacy, some content in this message has been blocked. To re-enable the blocked features, click here.
To always show content from this sender, click here.
You replied on 3/23/2015 4:20 PM.
Dear Ms. Bevan,

Thank you for your interest in the Moral Distress Scale — Revised (MDS-R). There are six versions of this scale: nurse, physician and other healthcare professional versions for adult settings (including ICUs and other inpatient units), and parallel versions for healthcare providers in pediatric settings. The MDS-R shows evidence of reliability and validity, and a publication describing the instrument and its testing has been published in the American Journal of Bioethics: Primary Research:


You should read this article before deciding whether the MDS-R will be appropriate for your project.

The MDS-R has a unique scoring scheme, designed to give a measure of current level of moral distress. Conceptually, items that have never been experienced or are not seen as distressing do not contribute to an individual’s level of moral distress. As noted, the Likert scales for each item have been adjusted to 0-4 from Corley’s original 1-7 scoring range. To generate a composite score, the frequency score and intensity (named “level of disturbance”) score for each item should be multiplied; note that this results in eliminating items never experienced or not distressing from the composite score. In addition, items rarely experienced or minimally distressing have low scores and items experienced frequently and as most distressing have higher scores. Each item product of frequency and intensity will range from 0 to 16. To obtain a composite score of moral distress, these individual item products should be added together. Using this scoring scheme allows all items marked as never experienced or not distressing to be eliminated from the score, giving a more accurate reflection of actual moral distress. The resulting score based on 21 items will have a range of 0 – 336.
Appendix M

Psychological Empowerment Scale

Psychological Empowerment Instrument
Listed below are a number of self-orientations that people may have with regard to their work role. Using the following scale, please indicate the extent to which you agree or disagree that each one describes your self-orientation.

<table>
<thead>
<tr>
<th>A. Very Strongly Disagree</th>
<th>E. Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Strongly Disagree</td>
<td>D. Neutral</td>
</tr>
<tr>
<td>C. Disagree</td>
<td>F. Strongly Agree</td>
</tr>
<tr>
<td>G. Very Strongly Agree</td>
<td></td>
</tr>
</tbody>
</table>

___ I am confident about my ability to do my job.
___ The work that I do is important to me.
___ I have significant autonomy in determining how I do my job.
___ My impact on what happens in my department is large.
___ My job activities are personally meaningful to me.
___ I have a great deal of control over what happens in my department.
___ I can decide on my own how to go about doing my own work.
___ I have considerable opportunity for independence and freedom in how I do my job.
___ I have mastered the skills necessary for my job.
___ The work I do is meaningful to me.
___ I have significant influence over what happens in my department.
___ I am self-assured about my capabilities to perform my work activities.

The scale is composed of 4 subdimensions: meaning, competence, self-determination, and impact. You may use the subdimensions on their own or take the mean of the 4 subdimensions to create an overall empowerment score. The validation of the instrument is described in Spreitzer (1995; 1996). The instrument has been used successfully in more than 50 different studies in contexts ranging from nurses to low wage service workers to manufacturing workers.

The validity of the instrument is very good. Test retest-reliability has been shown to be strong and validity estimates for the dimensions are typically around .80. More information on the empowerment profiles for different contexts and norm data for the empowerment dimensions can be found in Spreitzer and Quinn (2001).

References


Translated into Chinese by JWS-Hong Kong. Translated into Dutch by Thema B.V.
Appendix N

Permission for PES

Email message relaying permission to use PES tool

Gretchen Spreitzer <spreitze@umich.edu>
Fri 2/20/2015 4:13 PM
To: 
Bevan, Nancy A. (UMKC-Student);
You replied on 2/21/2015 12:42 PM.
Hello Nancy, yes, you are welcome to use the psychological empowerment instrument. Please share your findings with me so that I can learn from you. Best wishes.
Appendix O

Conditions of Work Effectiveness Questionnaire - II

The following 4 scales refer to Kanter’s 4 empowerment structures: access to opportunity, information, support and resources.

**HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Challenging work</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>2. The chance to gain new skills and knowledge on the job.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>3. Tasks that use all of your own skills and knowledge.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
</tbody>
</table>

**HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>No Knowledge</th>
<th>Some Knowledge</th>
<th>Know A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The current state of the hospital.</td>
<td>1 2 3 4  5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The values of top management.</td>
<td>1 2 3 4  5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The goals of top management.</td>
<td>1 2 3 4  5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific information about things you do well.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>2. Specific comments about things you could improve.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>3. Helpful hints or problem solving advice.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
</tbody>
</table>

**HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Scale Description</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time available to do necessary paperwork.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>2. Time available to accomplish job requirements.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
<tr>
<td>3. Acquiring temporary help when needed.</td>
<td>1</td>
<td>2</td>
<td>3 4  5</td>
</tr>
</tbody>
</table>

The following 2 subscales are measures of Kanter’s formal (Job Activities Scale or JAS) and informal power (Organizational Relationships Scale or ORS).
The following 2 subscales are measures of Kanter’s formal (Job Activities Scale or JAS) and informal power (Organizational Relationships Scale or ORS).

### JAS
**IN MY WORK SETTING/JOB:**

<table>
<thead>
<tr>
<th>Item</th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The rewards for innovation on the job are</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>2. The amount of flexibility in my job is</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>3. The amount of visibility of my work-related activities within the institution is</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
</tbody>
</table>

### ORS
**HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Item</th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaborating on patient care with physicians.</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>2. Being sought out by peers for help with problems</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>3. Being sought out by managers for help with problems</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
</tbody>
</table>

The 2-item global empowerment subscale listed below is used only for construct validation and is not included in the total empowerment score.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, my current work environment empowers me to accomplish my work in an effective manner.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Overall, I consider my workplace to be an empowering environment.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE - II

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Kind of Opportunity</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The chance to gain new skills and knowledge on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tasks that use all of your own skills and knowledge.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Kind of Information</th>
<th>No Knowledge</th>
<th>Some Knowledge</th>
<th>Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current state of the hospital.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The values of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The goals of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Kind of Support</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific information about things you do well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Specific comments about things you could improve.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Helpful hints or problem solving advice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Kind of Resource</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time available to do necessary paperwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Time available to accomplish job requirements.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Acquiring temporary help when needed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

IN MY WORK SETTING/JOB:

<table>
<thead>
<tr>
<th>Kind of Feedback</th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rewards for innovation on the job are</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The amount of flexibility in my job is</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The amount of visibility of my work-related activities within the institution is</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaborating on patient care with physicians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Being sought out by peers for help with problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Being sought out by managers for help with problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Seeking out ideas from professionals other than physicians, e.g.,</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Physiotherapists, Occupational Therapists, Dieticians.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, my current work environment empowers me to accomplish my work in an effective manner.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Overall, I consider my workplace to be an empowering environment.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
Appendix P

Permission Conditions of Work Empowerment Scale

From: nabhcf@mail.umkc.edu
To: hkl@uwo.ca
Subject: Empowerment Questionnaire Request Form
CC: instrhkl@uwo.ca

NURSING WORK EMPOWERMENT SCALE Request Form

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Questionnaires Requested:
- Conditions of Work Effectiveness-I (includes JAS and ORS):
- Conditions of Work Effectiveness-II (includes JAS-II and ORS-II): Yes
- Job Activity Scale (JAS) only:
- Organizational Relationship Scale (ORS) only:
- Organizational Development Opinionnaire or Manager Activity Scale:
- Other Instruments:

Please complete the following information:

Date: 02/16/2015
Name: Nancy Bevan
Title: Using Oppression Theory to Conceptualize the Phenomenon of Moral Distress in Nursing
University/Organization: University of Missouri, Kansas City
Address: 106 Apgar Drive (my home address)
Loveland, Ohio
Appendix Q

Recruitment Letter, AACN Web-site

Moral Distress Research Opportunity | The Greater Cincinnati Chapter of AACN | Nursing Network

Greater Cincinnati Chapter of AACN
Fostering relationships within the community

Moral Distress Research Opportunity
Posted 23 days ago by Tessa Messinger
(https://www.nursingnetwork.com/nurses/392441-tessa-messinger)

This communication is being distributed on the behalf of a chapter member. The Greater Cincinnati Chapter of The American Association of Critical Care Nurses is not associated with this study.

Dear AACN member:

I am conducting a research study investigating an intervention to help nurses who have experienced moral distress. Moral distress happens when nurses have to act against their personal and professional values, often resulting in personal suffering for the nurse. The symptoms listed below are suggestive of moral distress.

You are a candidate for this study if you have been a critical care nurse for at least one year, and have experienced at least one of the following symptoms as a result of nursing care you provided during a morally troubling patient care situation.

- anguish
- sleeplessness
- nausea
- migraines
- gastrointestinal upset
- tearfulness
- self-blame
- self criticism
- anger
- sarcasm
- guilt
- frustration
- sadness
- withdrawal
- betrayal of values
- insecurity
- remorse

The study will consist of three group educational sessions, and one individual interview. Your total time commitment is expected to be 11 hours. You will be compensated monetarily for your time.

Please contact Nancy Bevan at 513-646-4938 or nancy_bevan@trihealth.com if you are interested in participating in this study.

Thank you
Appendix R

AACN Permission Email

To: Bevan, Nancy
Inbox

You replied on 7/27/2016 10:42 AM.
Hi Nancy,
I have reset the website counter today. So you can just check our website when you need to see a count of website hits.
We have 163 followers on Facebook. 52 followers on Twitter.

When you are ready, just email me directly what you’d like promoted on our site/social media.

Thanks!
-Tessa

Tessa Messinger RN BSN CCRN-K
Cardiovascular Research Coordinator
The Lindner Research Center

From: Bevan, Nancy [mailto:Nancy_Bevan@trihealth.com]
Sent: Tuesday, July 26, 2016 10:30 AM
To: Messinger, Tessa <Tessa.Messinger@thechristhospital.com>
Appendix S

Room Permission

Tri-Health Fitness and Health Pavilion Event Rental/Use Agreement

Name of Organization or Person Renting (*Renter*): Nancy Davis
Name of Contact Person for Renter if Renter is comprised of an organization: 
Address: 543 Maple Ave
City: Cincinnati, OH
Phone #: Home 513-414-3457 Work 513-414-3458 Cell 513-414-3458
Email: Nancy.Davis@TriHealth.com

Total Amount $0

Reservation Date(s): October 10, 2017

Desired Start Time: 9:00 am End Time: 5:00 pm (including set-up and clean-up time)

Describe in detail the specific reason/purpose for the reservation (i.e., baseline nature of event, e.g., type of summer camp, educational session [14 people, 4 small tables, no audiovisual]):

Total # of people attending: [ ] Will the event be primarily attended by persons under the age of 18? [ ] Yes [ ] No
Please note: The Pavilion Rules & Regulations attached require a responsible adult, age 21 or over, be in charge of children and present at all times during entrance for activities involving minors.

Has or will this event be advertised and/or announced publicly in any way? Yes [ ] No [ ]
If yes, please attach a copy of the advertisement or announcement and list of places where it will be circulated and/or posted:

Payment Information: Are you paying by credit card or check? Credit card [ ] check [ ]

Credit Card Number: [ ]
Expiration Date: [ ]

The undersigned hereby acknowledges and agrees, on behalf of the Renter named above:

To follow all the Pavilion's Rules & Regulations attached to this page and acknowledges receipt of the same.

That Tri-Health Fitness & Health Pavilion (the "Pavilion") reserves the right, in its sole discretion, to unilaterally cancel and/or revoke the rental agreement and/or terminate the rental agreement in progress, for any reason, including but not limited to: (i) violation of the rules of the Pavilion; (ii) for noncompliance with any applicable federal or local law or regulation.

That the Renter will indemnify, defend and hold harmless the Pavilion, its parents, officers, agents, employees and military personnel from and against any and all claims, damages, losses, liabilities, judgments and expenses, of whatever nature, including reasonable attorney fees which are caused in whole or in part by any act or omission of Renter or Renter's employees, officers, agents, independent contractors, students, guests and/or invitee program participants/attendees while at the Pavilion in connection with the Agreement.

The undersigned, signing on behalf of the above-named Renter, has the authority as an authorized representative of the Renter to bind the terms and conditions of this Agreement.

[Signature of Renter]
[Signature of Pavilion Representative]

7/10/2017

211
Appendix T

IRB Approval

NOTICE OF NEW APPROVAL

Principal Investigator: Dr. Jennifer Hunter
2404 Charlotte St
Kansas City, MO 64108

Protocol Number: 17-092
Protocol Title: Development and Pilot Test of a Conscientization Intervention for Nurses who have Experienced Moral Distress
Type of Review: Designated Review
Expedited Category #: 6, 7

Date of Approval: 07/10/2017
Date of Expiration: 07/09/2018

Dear Dr. Hunter,

The above referenced study, and your participation as a principal investigator, was reviewed and approved, under the applicable IRB regulations at 21 CFR 50 and 56 (FDA) or 45 CFR 46 (OHRP), by the UMKC IRB. You are granted permission to conduct your study as described in your application.

Your protocol was approved under Expedited Review Regulatory Criteria at 45 CFR 46.110 or 21 CFR 56.110 under Category #6 as follows:
6. Collection of data from voice, video, digital, or image recordings made for research purposes.

Your protocol was approved under Expedited Review Regulatory Criteria at 45 CFR 46.110 or 21 CFR 56.110 under Category #7 as follows:
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

This approval includes the following documents:

Attachments
Bevan proposal approval copy
Appendix A AACN permission
Appendix C room permission
Appendix D Demographic Information
Appendix E MDS-R
Appendix F Permission MDS-R
Appendix G PES Scale copy 2
Appendix H permission PES
Appendix I CIWCI_R_Instrument
Appendix J CIWCI permission
Appendix K Bevan Training Schematic One
Appendix U

Post-Intervention Interview

**Feasibility Questions**

15. What is your satisfaction with the length of the overall program and individual sessions?

16. Was the flow of information logical to you?

17. Were the surroundings comfortable?

18. Problems with location, childcare, transportation, or parking; and degree of “safe space” perceived in relation to location; and concerns with privacy and confidentiality?

19. What, if anything, would you change about this intervention?

**For those participants that didn't finish the complete program**

20. Can you tell me why you did not finish the program?

21. Were there any specific topics covered that you were not comfortable with?
Appendix V

Post-intervention Interview–Empowerment Outcome Questions

1. What was your overall impression of this intervention?

2. Can you describe the most helpful thing that you learned in this intervention?

3. Can you tell me how this changed your understanding about the causes of moral distress?

4. How would you describe the most surprising thing you learned during the intervention?

5. How do you think what you have learned during the intervention will help you in the future?

6. Are there other life situations that you could apply what you have learned?

7. Can you tell me if you feel empowered enough to carry out your action project?

8. What did you learn about yourself?

9. What did you learn about nurses in the workplace?

10. Was the group dynamic helpful?

11. Are there any support systems that you will be using in the future?

12. Can you tell me how this intervention will help you decide how to handle any morally distressing situations different in the future?

13. Do you feel that you do have power within the organization?, If so, why do you think that nurses may not perceive that they actually have power?

14. Do you think that there is a difference between real power and perceived power?
## Appendix W

### Moral Distress Story Coding, Nurse A

<table>
<thead>
<tr>
<th>SENTENCE Nurse A</th>
<th>CODE</th>
<th>THEME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Elderly patient presented with shortness of breath, hyperkalemia, and increased lethargy.</td>
<td><strong>1. PT. PREVIOUS POOR PHYSICAL CONDITION</strong> <strong>2. SYMPTOMS-ALREADY COMPROMISED</strong></td>
<td><strong>SOURCE MD</strong> <strong>FUTILITY OF CARE</strong></td>
</tr>
<tr>
<td>2. Patient admitted to ICU for monitoring.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 2. Previous admissions with patient indicated she wished to be a Do Not Resuscitate.</td>
<td><strong>2. DOCUMENTATION THAT DID NOT WANT THIS!!</strong></td>
<td><strong>PT. NOT ALLOWED TO DIE</strong></td>
</tr>
<tr>
<td>4. 3. Patient unable to make decisions at this point and eventually declined to the 4 point of intubation.</td>
<td><strong>3. DECISION MAKING INCAPACITY</strong> <strong>4. DID SHE WANT THIS ?</strong></td>
<td><strong>SOURCE MD</strong> <strong>MULTIPLE INVASIVE PROCEDURES</strong></td>
</tr>
<tr>
<td>5. 5. Patient intubated with consent of daughter who was coming in from out of town.</td>
<td><strong>5. FAMILY OVERRODE MOTHER’S WISHES</strong> <strong>6. FAMILY NOT AROUND</strong></td>
<td><strong>POWER DYAMICS</strong> <strong>FAMILY- WONT HONOR PT WISHES</strong></td>
</tr>
<tr>
<td>6. 7. Patient remained in ICU for many months requiring 8 tracheostomy/ PEG tube for feeding, hemodialysis.</td>
<td><strong>7. TOO LONG SUFFERING- MANY MONTHS</strong> <strong>8. NAMING AGGRESSIVE LIFE PROLONGING TREATMENTS</strong></td>
<td><strong>SOURCE-MD</strong> <strong>MULTIPLE INVASIVE PROCEDURES</strong></td>
</tr>
<tr>
<td>7. 9. Patient unresponsive since intubation, 10 but daughter, 11 who was a lawyer, and 12 MDs and administration were 13 afraid to confront her.</td>
<td><strong>9. NO IMPROVEMENT FUTILE CARE</strong> <strong>10. FAMILY INTERFERING - OPPRESSION</strong> <strong>11. THREATENING – GIVES IMPRESSION OF POWER OVER</strong></td>
<td><strong>POWER- FAMILY UNREALISTIC EXPECTATION POWER- ORGANIZATION SIDE WITH FAMILY</strong></td>
</tr>
<tr>
<td>8. <strong>14</strong> Continued life prolonging treatments, multiple cardiac arrests, and Continuous Renal Hemodialysis Therapy.</td>
<td>14. <strong>UNREASONABLE LIFE PROLONGING-MULTIPLE COMORBITIES ADDING TO FUTILITY</strong></td>
<td>SOURCE MD -MULTIPLE INVASIVE PROCEDURES</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>9. <strong>15</strong> Patient code status was changed to DNR after 3-4 months of this and multiple meetings with daughter, administration.</td>
<td><strong>15. GREAT EFFORT NEEDED- TOO MUCH TOO LONG, TOO LATE</strong></td>
<td>SOURCE MD EXTREME MEASUREMENTS UNWANTED BY PATIENT</td>
</tr>
<tr>
<td>10. <strong>16</strong> She was eventually allowed to die naturally.</td>
<td><strong>16 WHAT SHE WANTED ALL ALONG- COULD HAVE PREVENTED THIS AND NOT HAVE HER SUFFER</strong></td>
<td>SOURCE -MD PROLONGATION OF LIFE LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
Appendix X

Moral Distress Story Coding, Nurse K

<table>
<thead>
<tr>
<th>SENTENCE -Code K</th>
<th>CODE NUMBER</th>
<th>THEME CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The most recent event that was distressing had to do with a 99 year old.</td>
<td>146</td>
<td>AGE IS FACTOR IN SURVIVING</td>
</tr>
<tr>
<td>2. She was an Asian patient who was from a Long Term Care Facility.</td>
<td>147</td>
<td>POSSIBLE CULTURAL ISSUE?</td>
</tr>
<tr>
<td>3. She had trached, on the ventilator and unresponsive</td>
<td>148</td>
<td>DIAGNOSTICS FOR POOR OUTCOME</td>
</tr>
<tr>
<td>4. She would open her eyes spontaneously but that was all she could do.</td>
<td>149</td>
<td>POOR OUTCOME</td>
</tr>
<tr>
<td>5. Her family demanded everything be done for her and she was a full code.</td>
<td>150</td>
<td>FAMILY DEMANDS TO TREAT</td>
</tr>
<tr>
<td>6. Multiple tests and treatments continued to be done.</td>
<td>151</td>
<td>TORTURE</td>
</tr>
<tr>
<td>7. All week the physicians refused to address the issues of her age and vegetative state.</td>
<td>152</td>
<td>Physic NOT ADDRESSING ISSUES UNETHICAL VEGETATIVE STATE</td>
</tr>
<tr>
<td>8. No palliative care was ordered.</td>
<td>153</td>
<td>LACK OF FOLLOW-UP</td>
</tr>
<tr>
<td>9. We were frustrated because the family was demanding answers.</td>
<td>154</td>
<td>PHYSICIAN NOT TALKING TO FAMILY</td>
</tr>
<tr>
<td>10. The nurses were left to fill in the answers and the gaps the physicians refused to talk about.</td>
<td>157</td>
<td>ANGER MDS NOT DOING JOB</td>
</tr>
</tbody>
</table>
Appendix Y

Moral Distress Story Coding, Nurse F

<table>
<thead>
<tr>
<th>SENTENCE - Code F</th>
<th>CODE NUMBERS</th>
<th>THEME CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A little over a year ago, I was called with a new patient from the Emergency Room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was told that the patient was admitted with respiratory distress and that the ED attempted to increase the size of the patient’s tracheostomy.</td>
<td>83 CONCERN OVER PATIENT CONDITION UNSAFE</td>
<td>SOURCE MD-UNSAFE CARE</td>
</tr>
<tr>
<td>3. Upon arrival to the floor, the patient was in severe respiratory distress.</td>
<td>84 UNSAFE PATIENT UNSAFE SOURCE MD-UNSAFE CARE</td>
<td></td>
</tr>
<tr>
<td>4. A rapid response was called.</td>
<td>85 = NO OTHER CHOICE</td>
<td>POWER-PATIENT - WISHED NOT MET</td>
</tr>
<tr>
<td>5. After the patient was stabilized, I notified the attending physician of the rapid response.</td>
<td>86 = TRYING TO DO MY JOB</td>
<td>POWER-NURSE</td>
</tr>
<tr>
<td>6. I requested that the patient’s code status be changed to reflect the patient wishes (patient was listed as full code but wanted to be no code).</td>
<td>87 ADVOCATING PATIENT- NOT WISHED = AGAINST PATIENT WISHES</td>
<td>POWER-PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td>7. The physician proceeded to yell at me and refused to change the code status.</td>
<td>89, 90 OUTRAGE, ANGER</td>
<td>POWER-Physician NO DNR</td>
</tr>
<tr>
<td>8. The next morning the patient’s tracheostomy became dislodged and the patient arrested.</td>
<td>92 SHOULD’N’T HAVE CODED THE PATIENT</td>
<td>POWER-PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td>9. A code blue was called, and CPR was initiated because the code status had</td>
<td>93 UNNECESSARY</td>
<td>POWER PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td></td>
<td>94 UNETHICAL</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10. I’ll never forget the phone I made to the phone call that I had to make to the patient’s daughter that morning.</td>
<td>95, 96</td>
<td>RESPONSE OF NURSE-GUILT</td>
</tr>
<tr>
<td>11. Because we discussed what the patient would not have wanted that</td>
<td>97</td>
<td>LACK OF RESOLUTION</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix Z

Moral Distress Story Coding, Nurse B

<table>
<thead>
<tr>
<th>Sentence Code B</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A patient in TCU who have 17 very frequent admissions for 18 respiratory failure and sepsis.</td>
<td>17- COMPROMISED CHRONIC ILLNESS 18 CONSTANT SERIOUS CHRONIC ILLNESS DIAGNOSIS STATEMENT</td>
<td>SOURCE MD FUTILITY OF CARE</td>
</tr>
<tr>
<td>2. She is on a 19 chronic ventilator due to long-term COPD.</td>
<td>19 QUALITY OF LIFE?</td>
<td>SOURCE MD FUTILITY</td>
</tr>
<tr>
<td>3. 20 She has tube feeding.</td>
<td>20 QUALITY OF LIFE?</td>
<td>SOURCE MD MULTIPLE INVASIVE PROCEDURES</td>
</tr>
<tr>
<td>4. 21 Family 22 always refusing to speak to palliative care.</td>
<td>21 FAMILY NOT COOPERATIVE 22 FAMILY WITH HABITUAL NON COOPERATIVE</td>
<td>POWER- FAMILY ABANDONMENT</td>
</tr>
<tr>
<td>5. 23 The patient always seems angry and sad that she is in the condition that she is in 24, 25 while she is receiving care.</td>
<td>23 NOT RIGHT- PATIENT DOES NOT SEEM TO WANT ANY OF THIS 24 CARE THAT SHE DID NOT WANT 25 FEEL LIKE I AM TORTURING HER</td>
<td>POWER-PATIENT WISHED NOT HONORED NURSE RESPONSE- GUILT</td>
</tr>
<tr>
<td>6. 26 I believe the patient is wanting to die.</td>
<td>26 NOT FOLLOWING PATIENT WISHES- NOT RIGHT</td>
<td>POWER-PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td>7. The 27 family will not let her go.</td>
<td>27 FAMILY IS TO BLAME FOR THIS SUFFERING</td>
<td>LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
### Appendix AA

Moral Distress Story Coding, Nurse C

<table>
<thead>
<tr>
<th>Sentence Code C</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 28 We had a patient who came to ICU for BiPap but was quickly intubated.</td>
<td>28 PLAN CHANGED QUICKLY TO INTUBATION – MORE LIFE PROLONGING</td>
<td>SOURCE MD FUTILITY OF CARE</td>
</tr>
<tr>
<td>2. 29 She was full of cancer.</td>
<td>29 FUTILITY, QUALITY OF LIFE DIAGNOSIS STATEMENT</td>
<td>SOURCE MD FUTILITY OF CARE</td>
</tr>
<tr>
<td>3. 30 She even had mets to the brain and had received brain radiation.</td>
<td>30 MORE EVIDENCE OF FUTILITY</td>
<td>SOURCE MD FUTILITY OF CARE</td>
</tr>
<tr>
<td>4. 34 She was in her 70’s or 80’s.</td>
<td>34 ALSO NOT YOUNG – MORE FUTILITY</td>
<td>SOURCE MD- FUTILITY OF CARE</td>
</tr>
<tr>
<td>5. 31 She got 32 super-sick super-fast when admitted with a temperature of 108.</td>
<td>31 NO TIME TO WORK OUT PLAN? 32 POWERLESS COMPelled TO TREAT 33 DIAGNOSIS EVIDENCE ON HOW SICK SHE WAS</td>
<td>SOURCE MD MULTIPLE INVASIVE PROCEDURES</td>
</tr>
<tr>
<td>6. 34 She became unresponsive and had to be 35 paralyzed with medication at one point.</td>
<td>34 CRITICAL CONDITION 35 PARALYZED UNDER RESTRAINT</td>
<td>POWER- PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td>7. 36 Doctors and nurses didn't want to continue.</td>
<td>36 BOTH FEELING AWFUL AND POWERLESS</td>
<td>NURSE RESPONSE - POWERLESS</td>
</tr>
<tr>
<td>8. 37 We consulted Ethics after like a month.</td>
<td>37 TOO LONG TO GET AN ETHICS CONSULT</td>
<td>POWER- NURSE NOT SUPPORTED</td>
</tr>
<tr>
<td>10. 39 Our doctor’s ended up discontinuing all of the labs, arterial blood gases-everything.</td>
<td>39 ONE WAY TO GET SOMETHING DONE</td>
<td>LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
### Appendix BB

Moral Distress Story Coding, Nurse D

<table>
<thead>
<tr>
<th>Sentence Code D</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>47</strong> Pt on a ventilator since 2014.</td>
<td>47. DIAGNOSIS- QUALITY OF LIFE</td>
<td>SOURCE MD- FUTILITY</td>
</tr>
<tr>
<td>2. <strong>48, 49, 50</strong> She had a wound on coccyx, PEG tube, runs of V-tach on the monitor.</td>
<td>48. NAMING FUTILITY OF CARE 49 FEEDING TUBE FUTILITY 50 WOUND</td>
<td>SOURCE MD – FUTILITY</td>
</tr>
<tr>
<td>3. <strong>51</strong> She just had a very poor quality of life.</td>
<td>51 POOR QUALITY OF LIFE</td>
<td>SOURCE MD FUTILITY</td>
</tr>
<tr>
<td>4. <strong>52</strong> Family NOT in see the patient.</td>
<td>52 FAMILY NOT INVOLVED</td>
<td>POWER- FAMILY ABANDONMENT</td>
</tr>
<tr>
<td>5. <strong>53</strong> Family NOT calling or checking on patient.</td>
<td>53 FAMILY NOT INVOLVED</td>
<td>POWER-FAMILY ABANDONMENT</td>
</tr>
<tr>
<td>6. <strong>54</strong> Patient not following commands and not even tracking with eyes.</td>
<td>54 DIAGNOSIS POOR QUALITY OF LIFE</td>
<td>SOURCE MD- FUTILITY</td>
</tr>
<tr>
<td>7. <strong>55, 56</strong> Family wants everything done even though not seeing patient.</td>
<td>55 FAMILY OPPRESSIVE AND CRUEL 56 FAMILY NOT INVOLVED</td>
<td>POWER-FAMILY ELDER ABUSE</td>
</tr>
<tr>
<td>8. <strong>57, 58</strong> Palliative care not able to reason with one of the family members.</td>
<td>57 FAMILY NOT LISTENING 58 LACK OF RESPONSE FROM PALLIATIVE CARE</td>
<td>POWER- FAMILY- ABANDONMENT AND UNREALISTIC EXPECTATIONS</td>
</tr>
<tr>
<td>10. <strong>60</strong> Pt. in hospital for multiple weeks and not really doing anything to improve quality of life.</td>
<td>60 FUTILE, CARE</td>
<td>LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
Appendix CC

Moral Distress Story Coding, Nurse E

<table>
<thead>
<tr>
<th>Sentence Code E</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 64 Three years ago I took care of a patient who was an alcoholic and drug addict.</td>
<td>64 3 YEARS STILL STUCK IN MIND</td>
<td></td>
</tr>
<tr>
<td>2. 65 He was in his early 30’s.</td>
<td>65 SAD- JUDGEMENT</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>3. 66 While caring for him, his girlfriend was with him during his hospital stay.</td>
<td>66 NEXT OF KIN</td>
<td></td>
</tr>
<tr>
<td>4. 67 He was in the hospital for over two weeks.</td>
<td>67 BECAME CLOSE TO PATIENT</td>
<td>SOURCE MD</td>
</tr>
<tr>
<td>5. Over the course of caring for him, I got to know him and her very well.</td>
<td>68 FAMILIARITY, CARING</td>
<td>RESPONSE OF NURSE-CARING</td>
</tr>
<tr>
<td>6. 69 She had three little children.</td>
<td>69 CONCERN</td>
<td></td>
</tr>
<tr>
<td>7. 70 Over the course of caring for him, I started to notice negative body language and some fear in her.</td>
<td>70 CONCERN, WORRY</td>
<td>SOURCE MD UNSAFE SITUATION</td>
</tr>
<tr>
<td>8. 71 While the patient was off the floor for a test, she confided in me that he could be verbally and physically abusive towards her.</td>
<td>71 FEAR, CONCERN NOT SURPRISED</td>
<td>SOURCE MD- UNSAFE SITUATION</td>
</tr>
<tr>
<td>9. 72 I told my charge nurse and the Chaplain and social worker.</td>
<td>72 CARRIED THROUGH-RESPONSE</td>
<td></td>
</tr>
<tr>
<td>10. 73 She was given information and resources on how to get help.</td>
<td>73 REGRET HER NOT HAVING CHANCE</td>
<td>RESPONSE OF THE NURSE- GUILT</td>
</tr>
<tr>
<td>11. 74 I worried about her.</td>
<td>74 WORRY</td>
<td>RESPONSE OF NURSE-WORRY</td>
</tr>
<tr>
<td>12. 75 I also told the</td>
<td>75 SHARE CONCERN</td>
<td></td>
</tr>
</tbody>
</table>
doctors of my concern.

13. **76** When he was discharged, I was off work that day.  

76. COULDN'T FOLLOW UP  

NURSE RESPONSE—GUILT

14. **77** I came back the next day and was told by a co-worker in the clean utility room that he had murdered her.  

77. HORROR, ANGER  

WHY UTILITY ROOM  

ANGER AT COWORKER  

NURSE REPONSE—HORROR, ANGER

15. **78** I felt like I was going to throw up.  

78. PHYSICAL HORROR  

RESPONSIBLE  

RESPONSE OF NURSE—PHYSICAL

16. **79** I had nightmares for a long time.  

79. RESPONSIBLE, GUILT  

RESPONSE OF NURSE—GUILT

17. **80** I felt helpless.  

80. POWERLESS HELPLESS  

RESPONSE OF NURSE

18. **81** My assistant manager at the time asked if I wanted to speak to a grief counselor, but I declined.  

81. DIDN'T UNDERSTAND  

THOUGHT I SHOULD HANDLE IT ON MY OWN  

RESPONSE OF THE NURSE—GUILT  

LACK OF RESOLUTION
<table>
<thead>
<tr>
<th>Sentence Code G</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 90 Elderly patient admitted from a Florida Hospital around New Years with End Stage Renal Failure, septic, necrotic feet up to mid-calf.</td>
<td>90 DIAGNOSIS FOR FUTILE CARE</td>
<td>SOURCE MD- FUTILITY OF CARE</td>
</tr>
<tr>
<td>2. She had lots of other medical problems as well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 91 The most complex dynamic of this was her daughter.</td>
<td>91 FAMILY ISSUE AGAIN</td>
<td>POWER- FAMILY</td>
</tr>
<tr>
<td>4. 92 She was a well-known and powerful person in Cincinnati</td>
<td>92 BULLY, POWER, TERROR</td>
<td>POWER FAMILY</td>
</tr>
<tr>
<td>5. 93 She was definitely a perfectionist, and a very controlling person.</td>
<td>93. CONTROLLING</td>
<td>POWER-NURSE- FEAR OF FAMILY</td>
</tr>
<tr>
<td>6. 94 She never had children, and she referred to her Mom as her “baby.”</td>
<td>94. ODD FAMILY DYNAMIC</td>
<td>POWER- FAMILY</td>
</tr>
<tr>
<td>7. 95 It took weeks of tough conversations with the daughter her code status was changed to “no compressions.”</td>
<td>95. FINALLY SOME RELIEF</td>
<td>POWER FAMILY WON’T FOLLOW PATIENT WISHES</td>
</tr>
<tr>
<td>8. 96 Daughter only left for a few hours every day.</td>
<td>96 UNHEALTHY BEHAVIOR FROM DAUGHTER</td>
<td>POWER- NURSE FEAR OF FAMILY</td>
</tr>
<tr>
<td>9. 97 Wouldn’t you know that she coded during the several hours when she was gone and this happened to be on night shift.</td>
<td>97 MOTHER TRYING TO DIE</td>
<td>POWER NURSE-FEAR OF FAMILY</td>
</tr>
<tr>
<td>10. 98 The senior resident refused to call the daughter and made the first year resident do it</td>
<td>98 OPPRESSION, POWER, BULLYING, COWARD</td>
<td>POWER- ORGANIZATION FEAR FAMILY</td>
</tr>
<tr>
<td>11. 99 We all thought that this patient’s suffering had come to an end (January until</td>
<td>99 TOO LONG- UNETHICAL DRAINING TO STAFF</td>
<td>SOURCE MD MULTIPLE MEDICAL INVASIVE PROCEDURE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Summer- 6 months !!!!! of this.</strong></td>
<td><strong>FUTILE CARE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>12. 100.</strong> Of course we were afraid of a lawsuit from the daughter so it was the best code we every performed.</td>
<td><strong>100. POWER FEAR OPPRESSION</strong></td>
<td><strong>POWER- FAMILY FEAR OF LAWSUIT</strong></td>
</tr>
<tr>
<td><strong>13. 101.</strong> Once she got there-she asked us to stop- we thought it was all over – finally!!!</td>
<td><strong>101. HOPE SUFFERING NO MORE</strong></td>
<td><strong>LACK OF RESOLUTION</strong></td>
</tr>
<tr>
<td><strong>14. 102.</strong> No more suffering !!!!!</td>
<td><strong>102. RELIEF FINALLY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>15. 103.</strong> Somehow- the patient got her pulse back.</td>
<td><strong>103. WE SHOULD NEVER HAVE CODED HER IN THE FIRST PLACE</strong></td>
<td><strong>LACK OF RESOLUTION</strong></td>
</tr>
<tr>
<td><strong>16. 104.</strong> Lived for a few more months !!!!!</td>
<td><strong>104. HORRIBLE, HARD ON STAFF</strong></td>
<td><strong>LACK OF RESOLUTION</strong></td>
</tr>
<tr>
<td><strong>17. 105.</strong> Disappointed in our physicians because they let the daughter intimidate them and everyone.</td>
<td><strong>105. UNETHICAL STAFF DON'T MATTER</strong></td>
<td><strong>POWER FAMILY-POWER-ORGANIZATION SIDE WITH POWERFUL FAMILY</strong></td>
</tr>
</tbody>
</table>
Appendix EE

Moral Distress Story Coding, Nurse H

<table>
<thead>
<tr>
<th>Sentence Code</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Very busy with two patients, one of which was elderly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. One of the patient’s grandson kept walking into the other patient’s room while I was caring for another patient.</td>
<td>107 FAMILY INTERFERENCE IN ANOTHER PATIENT ROOM</td>
<td>POWER- FAMILY UNREALISTIC EXPECTATIONS-</td>
</tr>
<tr>
<td>3. He was saying that his grandmother was in pain and they wanted some more pain medicine.</td>
<td>108 URGENCY BY FAMILY</td>
<td></td>
</tr>
<tr>
<td>4. The patient was going to die and a palliative care meeting was scheduled with the family in one hour.</td>
<td>109 PLANS MIGHT CHANGE 110 LETS GET PLAN DOWN</td>
<td>POWER FAMILY UNREALISTIC EXPECTATIONS</td>
</tr>
<tr>
<td>5. Explained to grandson that wanted to keep her comfortable but not overly sedate her.</td>
<td>111 EDUCATION FOR FAMILY</td>
<td></td>
</tr>
<tr>
<td>6. He kept coming and I gave the patient several more doses of Dilaudid.</td>
<td>112 PUSHING PAIN MEDICINE</td>
<td></td>
</tr>
<tr>
<td>7. Patient still became agitated – pulling at IV lines and wires.</td>
<td>113 WANTED TO CALM HER DOWN FAMILY UPSET</td>
<td>SOURCE MD- FUTILITY OF CARE</td>
</tr>
<tr>
<td>8. Because of her agitation I gave her a very small dose of Ativan.</td>
<td>114 APPROPRIATE CARE BUT FELT FORCED</td>
<td>POWER-FAMILY UNREALISTIC EXPECTATIONS</td>
</tr>
<tr>
<td>9. The patient became</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. **115** Daughter came in at that time and wanted the Ativan reversed- so counter medicine was given.  

11. **116** The patient went asystole and coded.  

12. **117** Daughter turned to me and said, “You killed my mother.”  

13. **118** The patient only had several days to live.  

14. **119** I was so upset that I had the manager take over the care of my patients.

<table>
<thead>
<tr>
<th>Number</th>
<th>Text</th>
<th>Label</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>115</td>
<td>FAMILY DEMANDING CARE REVERSAL FAMILY MISCOMMUNICATION</td>
<td>POWER- FAMILY UNREALISTIC EXPECTATIONS</td>
<td></td>
</tr>
<tr>
<td>116</td>
<td>SHOCK, SURPRISE</td>
<td>RESPONSE OF NURSE</td>
<td></td>
</tr>
<tr>
<td>117</td>
<td>SHOCK DISBELIEF</td>
<td>RESPONSE OF NURSE-SHOCK</td>
<td></td>
</tr>
<tr>
<td>118</td>
<td>FUTILE CARE, SENSELESS CLAIM</td>
<td>LACK OF RESOLUTION</td>
<td></td>
</tr>
<tr>
<td>119</td>
<td>DOWN SHUT Couldn’t Work With Patient</td>
<td>RESPONSE OF NURSE-SHUTDOWN</td>
<td></td>
</tr>
</tbody>
</table>
Appendix FF

Moral Distress Story Coding, Nurse I

<table>
<thead>
<tr>
<th>Sentence Code</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I had a patient that was admitted for respiratory distress.</td>
<td>119 DIAGNOSIS</td>
<td></td>
</tr>
<tr>
<td>2. She was just diagnosed with lung cancer.</td>
<td>120 POOR CHANCE AT OUTCOME</td>
<td>SOURCE MD- FUTILITY OF CARE</td>
</tr>
<tr>
<td>3. She was in her forties and divorced and had a sister that was estranged.</td>
<td>121 YOUNG 122 FAMILY ESTRANGED</td>
<td></td>
</tr>
<tr>
<td>4. She was placed on Bi-Pap and kept removing it so we placed her in restraints.</td>
<td>122 DID SHE NOT WANT THIS 123 TOOK THE CHOICE AWAY FROM HER</td>
<td>POWER PATIENT- WISHES NOT BEING FOLLOWED</td>
</tr>
<tr>
<td>5. She died on Bi-Pap and in restraints.</td>
<td>124 TRAGIC</td>
<td>LACK OF RESOLUTION</td>
</tr>
<tr>
<td>6. Close personal friends came to visit her shortly after she died.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. we had been trying to contact next of kin who was the son.</td>
<td>125 FAMILY NOT PRESENT WHEN DIED</td>
<td>RESPONSE NURSE- GUILT</td>
</tr>
<tr>
<td>8. I told them I wouldn't release any information or allow them to see the patient until the next of kin was contacted.</td>
<td>126 FELT BAD NO FAMILY GOOD FRIENDS COULDN'T SEE PAT</td>
<td>NURSE RESPONSE – FELT BAD</td>
</tr>
<tr>
<td>9. They provided a brother as a contact and he gave me permission to update the friends who were the patient’s closest friends.</td>
<td>127 SAD DIED ALONE</td>
<td>NURSE REONSE GUILTY</td>
</tr>
<tr>
<td>10. My moral distress on this is placing patient on bi-pap and restraining them.</td>
<td>128 MORAL DISTRESS IDENTIFICATION</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>11. working on a patient to revive her and she doesn't want to be revived.</td>
<td></td>
<td>POWER- PATIENT WISHED NOT HONORED</td>
</tr>
</tbody>
</table>
12. Seeing the agony in the friends not knowing what was going on and being there for their friend. | **129 CAUSED AGONY** | **RESPONSE OF NURSE-GUILT**
<table>
<thead>
<tr>
<th>Sentence Code J</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I cared for a patient in the MSICU who had a 130 very supportive involved family.</td>
<td>130 SUPPORTIVE FAMILY</td>
<td></td>
</tr>
<tr>
<td>2. 131 They couldn't /wouldn't comprehend how sick their wife/mother really was.</td>
<td>131 FAMILY WOULDN'T COME TO GRIPS WITH CONDITION</td>
<td>POWER- FAMILY - UNREALISTIC EXPECTATIONS</td>
</tr>
<tr>
<td>3. She had a ruptured gastric ulcer in the beginning and her health had 132 spiraled downhill from there.</td>
<td>132- DIAGNOSTIC EXPLANATION</td>
<td>SOURCE MD- FUTILITY OF CAR</td>
</tr>
<tr>
<td>4. The biggest issue was determining her 133 mentation</td>
<td>133 COULD WE HONOR HER WISHES</td>
<td>WISHED NOT HONORED</td>
</tr>
<tr>
<td>5. She appeared to be alert and oriented – but it was quite disturbing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. 134 She refused ALL nursing care.</td>
<td>134 SHE DID NOT WANT CARE</td>
<td>POWER PATIENT WISHED NOT HONORED</td>
</tr>
<tr>
<td>7. 135 Believed that every nurse that walked into her room were evil and did not want the nurses near her.</td>
<td>135- HATED NURSES</td>
<td>RESPONSE OF NURSE - GUILT</td>
</tr>
<tr>
<td>8. 136 She wanted to DIE and her 137 family called her selfish and thought there was 138 still more life for her.</td>
<td>136 FAMILY KEPT PUSHING FOR HER TO GO ON 137 FAMILY CALLED PATIENT SELfish 138 FAMILY IS SELfish</td>
<td>POWER- FAMILY- UNREALISTIC EXPECTATION POWER- PATIENT WISHES NOT MET</td>
</tr>
<tr>
<td>9. 139 She wasn't quite “alert and oriented” yet by her statements she appeared to be and it was VERY confusing for me and the family, charge nurse, and physician.</td>
<td>139 DIFFICULT DUE TO MENTATION</td>
<td></td>
</tr>
<tr>
<td>10. 140 We went back and forth about code status.</td>
<td>140 INDECISION BECAUSE OF FAMILY</td>
<td>LACK OR RESOLUTION</td>
</tr>
<tr>
<td>11. FORCING patient care on her.</td>
<td>FORCING AGAINST WILL</td>
<td>POWER-PATIENT-FORCED INTO CARE WISHED NOT HONORED</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>12. I was so drained and frustrated by the end of the day.</td>
<td>NURSE DRAINED AND FRUSTRATED</td>
<td>NURSE RESPONSE-FRUSTRATION</td>
</tr>
<tr>
<td>13. The patient was miserable and ready to die.</td>
<td>PATIENT SUFFERING</td>
<td>POWER-PATIENT-WISHED NOT FOLLOWED</td>
</tr>
<tr>
<td>14. The family wasn't ready.</td>
<td>SELFISH FAMILY</td>
<td>POWER – FAMILY UNREALISTIC EXPECTATIONS</td>
</tr>
<tr>
<td>15. The patient wasn't entirely like herself – yet she seemed so sure and could make decisions.</td>
<td>FELT PATIENT KNEW BUT DIFFICULT</td>
<td>LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
Appendix HH

Moral Distress Story Coding, Nurse L

<table>
<thead>
<tr>
<th>Sentence Code L</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>From multiple patient care situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Over-involved in patient care.</td>
<td></td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>2. 156 I was having dreams.</td>
<td>156 DREAMS</td>
<td></td>
</tr>
<tr>
<td>3. I was having 157 forgetfulness and giving unsafe care.</td>
<td>157 FORGET AND UNSAFE CARE</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>4. My family has dynamics that influence all of this.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. 158 Am I going crazy?</td>
<td>158 CRAZY</td>
<td>RESPONSE OF NURSE-CRAZY</td>
</tr>
<tr>
<td>6. Am I getting Alzheimer’s ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I had to take 159 3 months off.</td>
<td>159 3 MONTHS OFF</td>
<td></td>
</tr>
<tr>
<td>8. 160 I didn't want to come back to work? Wasn't sure that I could come back to work.</td>
<td>160 STAY AWAY FROM WORK</td>
<td>RESPONSE OF NURSE-</td>
</tr>
<tr>
<td>9. Am I that 161 dog in a cage with an electric shock.</td>
<td>161 TRAPPED</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>10. Back to work now- back to work 162 first day and I am crying.</td>
<td>162 CRYING</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>11. 163 No manager and no support.</td>
<td>163 NO SUPPORT</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>12. I am still 164 an advocate.</td>
<td>164 MY ROLE</td>
<td></td>
</tr>
<tr>
<td>13. But still have those 165 “helping healing hands”</td>
<td>165 HELPING HEALING HANDS</td>
<td>RESPONSE OF NURSE</td>
</tr>
<tr>
<td>14. My feeling were validated when I had a 166 psychic reading telling me I had many patients telling me how much I had helped them.</td>
<td>166 AMAZING SURPRISE VALIDATION FROM BEYOND</td>
<td></td>
</tr>
<tr>
<td>15. I am looking 167 forward to retirement but still revert</td>
<td>167 CALLING</td>
<td>RESOLUTION</td>
</tr>
</tbody>
</table>
back to the bedside.
## Appendix II

Moral Distress Story Coding, Nurse M

<table>
<thead>
<tr>
<th>Sentence Code M</th>
<th>Code #</th>
<th>Theme Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I had an elderly male patient who I took care of about a year ago.</td>
<td>168</td>
<td>FAMILIARITY</td>
</tr>
<tr>
<td>2. He lived with his children in his house.</td>
<td>169</td>
<td>GROWN CHILDREN IN HIS HOUSE</td>
</tr>
<tr>
<td>3. The children didn't work.</td>
<td>170</td>
<td>FRELOADING FAMILY</td>
</tr>
<tr>
<td>4. He was brought to the hospital in very poor condition.</td>
<td>171</td>
<td>TERRIBLE FAMILY</td>
</tr>
<tr>
<td>5. He was malnourished and had multiple bedsores.</td>
<td>172</td>
<td>ELDER ABUSE FAMILY</td>
</tr>
<tr>
<td>6. He was dirty and smelled very bad.</td>
<td>173</td>
<td>ELDER ABUSE FAMILY</td>
</tr>
<tr>
<td>7. His family was unable or unwilling to care for him.</td>
<td>174</td>
<td>HE DESERVED BETTER</td>
</tr>
<tr>
<td>8. But they didn't want to bring him anywhere else.</td>
<td></td>
<td>RESPONSE OF NURSE-GUILT</td>
</tr>
<tr>
<td>9. I suspect because then they couldn't live in his house and use his social security checks.</td>
<td>175</td>
<td>CRIMINAL</td>
</tr>
<tr>
<td>10. His house and SS checks provided for the whole family.</td>
<td>176</td>
<td>CRIMINAL</td>
</tr>
<tr>
<td>11. I felt terrible that they didn't have enough respect for their father to take care of him.</td>
<td>177</td>
<td>NURSE FELT TERRIBLE EMPATHY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LACK OF RESOLUTION</td>
</tr>
</tbody>
</table>
Appendix JJ

Structural Code Data

Moral Distress Stories Structural Coding Grid
The letters A-M = participant code. AB= abstract, OB= observation, CA= critical incident, EV= evaluation, RE= resolution.
Coda= end the narrative.

<table>
<thead>
<tr>
<th>Participant code</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>Line in story</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>AB</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>OR</td>
<td>17</td>
</tr>
</tbody>
</table>
Appendix KK

Group 2 Intervention Data

Session One: Critical Reflection

During Session One: Critical Reflection, each participant from the small groups got to know each other by sharing information using the tool “Understanding Ourselves,” (Freire, 2016). Next, each participant wrote a personal moral distress story and shared that story with the large group. Then, each small group picked one story within their group to be used to evaluate three foci of culture, power, and resources. To end the session, each group weighed options for what could have been different or could have been done differently to avoid moral distress.

Learning stage: understanding ourselves. Next I describe the members of Group 2. Out of the three participants from this group, one was married with two children, the second was divorced with one child, and the third was single with no children. Two had been motivated to become nurses from previous positive experiences with nurses and family members. Two of the three had a BSN degree, while the third had an MSN degree. For two participants, nursing was a second career, one participant having switched after a career in cosmetology, and the other, after working as a professional in horse showing. Two of the three participants worked in a Progressive Care Unit (PCU), and the third worked in a Surgical Intensive Care Unit (SICU). Outside involvements included being active in the American Association of Critical Care Nurses (AACN) for one participant, while another was involved in church activities, and the last nurse was involved in horseback riding and training as well as the 4-H Club.
All three participants identified the Internet and their peers as their main source of information, followed by family members. One described society as “Sad” and “Depressing,” with another saying “Chaotic,” and the third stating that “We have a decrease in human contact.” Below is the moral distress story that was codified and chosen for Group 2 as written verbatim by Nurse A.

Elderly patient presented with shortness of breath, hyperkalemia, and increased lethargy. Patient admitted to ICU for monitoring. Previous admissions with the patient indicated she wished to be a Do Not Resuscitate. Patient unable to make decisions at this point and eventually declined to the point of intubation. Patient intubated with consent of daughter who was coming in from out of town. Patient remained in ICU for many months requiring tracheostomy/PEG tube for feeding, hemodialysis. Patient unresponsive since intubation, but daughter, who was a lawyer, and MDs and administration were afraid to confront her. Continued life prolonging treatments, multiple cardiac arrests, and Continuous Renal Hemodialysis Therapy. Patient code status was changed to DNR after 3-4 months of this and multiple meetings with daughter, administration. She was eventually allowed to die naturally.

**Learning stage: Understanding what already exists.** In the “Understanding What Already Exists” exercise (Freire, 2016). Below, I present the results of the groups’ decodification for the foci of culture, power, and resources as related to their moral distress story with the completed followed by group discussion. Figure 1 depicts the schematic representation.

![Figure 1. Understanding what already exists Group 2](image-url)
Following the group activity where the template was completed, the group discussed their findings with the entire group of participants via group discussion. Their analysis of the story highlighted several ways in which the story fit the three focal points of culture, power and resources. First the group identified that fact that the patient did not have the right to die as she had wished was from the culture focus. As Nurse A stated, “She should have had the right to make herself a DNR or at least had a conversation with her daughter from the beginning.” Another example of culture focus given by the group was the fact that there were no clear goals for this patient by noting “There were no clear goals of care for this patient. It’s kind of felt futile and exhausting for the staff because there was no end goal in mind.” The group gave examples of their story through the power focus, Nurse A “The daughter was the head of team, and the physicians came under her making decisions that she wanted them to make; the patient had the least power of all.”

Discussing the troubling scenario of the physicians being manipulated, Nurse A went on “The physicians were misusing the power that they had, they were being manipulated by the daughter in certain situations.” Nurse also went on to give examples of the resources focus “We did feel like we had backing from administration, do administrative support was not there. We had to deal with the daughter, the physicians and the staff all by ourselves.”

**Learning stage: Weighing options.** I present the results from the groups’ written exercise is displayed in Table 1. This exercise was done within each small group and the results were presented to the large group with no group discussion.
Table 1

*Weighing Options Group 2*

<table>
<thead>
<tr>
<th>Made moral distress situation worse</th>
<th>Would make moral distress situation better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict of interest with physicians and administration and daughter due to political and financial relationship with daughter</td>
<td>Debriefing after bad days</td>
</tr>
<tr>
<td>Bizarre behavior by daughter</td>
<td>Not permitting bad behavior of daughter</td>
</tr>
<tr>
<td>No end goals for patient care</td>
<td>Support by upper administration</td>
</tr>
<tr>
<td>Threatening behavior by daughter towards staff</td>
<td>Supporting patient’s right to die</td>
</tr>
<tr>
<td>Burnout among many staff nurses</td>
<td>Collaborative meetings</td>
</tr>
<tr>
<td></td>
<td>Clear sets of boundaries</td>
</tr>
<tr>
<td></td>
<td>Daughter-physician Counseling for daughters and physicians</td>
</tr>
<tr>
<td></td>
<td>Clarification of goals</td>
</tr>
<tr>
<td></td>
<td>Unit council/discussion</td>
</tr>
</tbody>
</table>

**Session Two: Critical Motivation**

*Learning stage: understanding where we wish to go.* The three foci of *culture, power, and resources*; are used again, however, in this exercise, they are looking at possible situations that could happen in the future (Freire, 2016). For the purpose of this exercise, we determined the “future” as the next ten years, the year 2027. Below in Figure 2 “Understanding Where We Wish to Go,” the arrows in the schematic represent the notion that the three foci should all equally impact the envisioned 2027 institution (Freire, 2016). This exercise was done within each small group and presented to the large group with no group discussion.
Figure 2. Understanding where we wish to go Group 2

Session Three: Critical Action

*Learning stage: strategy building, planning, resource-acquisition.*

Below, I present the results via the discussion regarding the groups’ Strategy Building exercise (Freire, 2016). In the individual focus, looking at the use of a confident voice, Nurse A talked about mentorship in the form of orientation, one nurse pointed out “When I started out. I had a great preceptor. She used to tell me to be part of the conversation and be confident when speaking.” Focusing on organizational foci, and example of building efforts between doctors and nurses comes from an experience that one nurse had as a student nurse in an organization. Nurse A described “I was a student nurse, and everybody went into the patient’s room during rounding. Everybody touched him, even me, and my opinion mattered, and they told me that.”

When discussing the institutional focus, examples given by the nurses were how helpful round table discussions were with another member of the group said “I had a patient who had a bad outcome. This type of round table was something that could help
by having the discussion and help everybody deal with it and figure out how to prepare the family for this.” Evaluating the effect of the governmental focus, one participant stated, “The government controls a lot of what is happening as far as payment and regulations.” Table 3 depicts the group action project.

Table 2

<table>
<thead>
<tr>
<th>Strategy Building, Planning, Resource-Acquisition, Implementation Group 2.</th>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals</strong></td>
<td>Nurses are respected a lot of the time</td>
<td>Lack of retention because individuals do not stay</td>
</tr>
<tr>
<td></td>
<td>Use confident voice can help</td>
<td>Inconsistent training with individuals</td>
</tr>
<tr>
<td></td>
<td>No fear of using your voice</td>
<td>Individuals punished for using their voice</td>
</tr>
<tr>
<td></td>
<td>Honesty</td>
<td></td>
</tr>
<tr>
<td><strong>Organizations</strong></td>
<td>Open discussions between leaders and employees</td>
<td>Time constraints</td>
</tr>
<tr>
<td></td>
<td>Efforts to build rapport between nurses and doctors</td>
<td>Focus on finance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient satisfaction</td>
</tr>
<tr>
<td><strong>Institutions</strong></td>
<td>Bedside manner class for physicians going on now</td>
<td>Old school nursing versus doctors</td>
</tr>
<tr>
<td></td>
<td>Self-awareness class</td>
<td></td>
</tr>
<tr>
<td><strong>Government</strong></td>
<td>National Health care would help to solve the problem of lack of health care and reimbursement</td>
<td>Let insurance company dictate peoples’ health care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consulting companies come in and require how things are going to be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insurance companies’ bottom line is money</td>
</tr>
</tbody>
</table>

Below, I present the results via the discussion regarding their Action Project Exercise (Freire, 2016). One nurse from the group stated “I think the nurse’s voice would be super important at a round table discussion. I think you would be more respected as a nurse to have more of a voice in this situation.” Another member added “I think if we
make it a consistent time, that would make a difference, otherwise it would be very hard to get it coordinated.” Nurse A spoke up “I have been a part of a round table, but it was after the fact, and at that time it was too late, this needs to be done before that.” A member from another group added “We have a patient right now where I work that would benefit from something like this.”

Table 3

*Group 2 Action Project*

<table>
<thead>
<tr>
<th>WHAT</th>
<th>Care Team Focus Round Table Discussions with staff nurses, physicians, management, and entire care team to collaborate on high acuity, long-term, or challenging family care situations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHY</td>
<td>To establish early, consistent, respectful, and open communication among all members of the care team; to consistently provide ethical and quality care.</td>
</tr>
<tr>
<td>WHEN</td>
<td>Weekly</td>
</tr>
<tr>
<td>WHERE</td>
<td>On the individual unit.</td>
</tr>
<tr>
<td>HOW</td>
<td>Open discussion in each unit led by the staff nurse and attended by physician, management, and entire care team.</td>
</tr>
</tbody>
</table>
Appendix LL

Group 3 Intervention Data

Session One: Critical Reflection

During Session One: Critical Reflection, each participant from the small groups got to know each other by sharing information using the tool “Understanding Ourselves,” (Freire, 2016). Next, each participant wrote a personal moral distress story and shared that story with the large group. Then, each small group picked one story within their group to be used to evaluate three foci of culture, power, and resources. To end the session, each group weighed options for what could have been different or could have been done differently to avoid moral distress.

*Learning stage: Understanding ourselves.* Next, I describe the members of Group 3. There were two participants, both were married with children. One participant had eight children, 28 grandchildren, and one great-grandchild, while the other had three grown children. Both of these nurses had been influenced by family members to become nurses, with one working in a telemetry unit, and the other, MICU. Both held BSN degrees, and one was in graduate school for her MSN. Volunteering was important to both, with one also being involved with her church’s activities.

One of the nurses openly shared that she was the oldest girl of six children and had had a troubled childhood. She was the victim of her mother’s Munchausen’s syndrome by proxy, and her father was an alcoholic. Both claimed the internet as their main source of information. Regarding their views on society, one stated she was discouraged by the evil she saw but also impressed by humankind’s resilience, and the other noted that people have become too detached from human feelings due to their
excessive use of technology in general. Below is the codification of the moral distress story chosen for Group 2 as written verbatim by Nurse K.

The most recent event that was distressing had to do with a 99 year-old. She was an Asian patient who was from a Long-Term Care Facility. She had been trached on the ventilator and was unresponsive. She would open her eyes spontaneously but that was all she could do. Her family demanded everything be done for her and she was a full code. Multiple tests and treatments continued to be done. All week the physicians refused to address the issues of her age, vegetative state. No palliative care was ordered. We were frustrated because the family was demanding answers. The nurse were left to fill in the answers and the gaps the physicians refused to talk about.

**Learning stage: Understanding what already exists.** Below, I present the results of Group 3’s decodification for the foci of culture, power, and resources as related to their moral distress story with the completed template in Figure 1, followed by group discussion (Freire, 2016).

*Figure 1. Understanding what already exists Group 3*

Following the group activity where the template was completed, this group discussed their findings with the entire group of participants via group discussion. Their analysis of the story highlighted several ways in which the story fit the three focal points of culture,
power and resources. First the group identified a culture focus by noting conflicting cultural values at the end of life. Nurse K added “The son dictated all of the rules and procedures. He refused any sort of suggestions of palliative care or end of life discussions.” Evaluating the power focus, Nurse K said that the son really controlled everything and the physician just caved in.

As Nurse K mentioned “The physician was not willing to address any issues with the family or son.” Nurse K also went on to give examples of the resources focus “The resources were not used, procedures were not followed even though we have the ability to use resources, they were not utilized.”

**Learning stage: Weighing options.** I present the results from the group’s written exercise (Freire, 2016). This exercise was done within each small group and the results were presented to the large group with no group discussion. Table 1 displays work done

**Table 1**

<table>
<thead>
<tr>
<th>Made moral distress situation worse</th>
<th>Would make moral distress situation better</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family of the patient not cooperating</td>
<td>Involvement of multiple departments and meetings</td>
</tr>
<tr>
<td>Lack of leadership</td>
<td>Physician leadership</td>
</tr>
<tr>
<td>No support from management</td>
<td>Services from HR available</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>Nurse liaison who can relate</td>
</tr>
<tr>
<td>Caring involvement</td>
<td>Increased feeling of fellowship</td>
</tr>
<tr>
<td></td>
<td>Increased on Broad sympathetic thoughts</td>
</tr>
</tbody>
</table>

**Session Two: Critical Motivation**

**Learning stage: understanding where we wish to go.** The three foci of *culture, power, and resources*; are used again, however, in this exercise, they are looking at possible situations that could happen in the future (Freire, 2016). For the purpose of this
exercise, we determined the “future” as the next ten years, the year 2027. Below is the schematic of Group 3 for the learning stage “Understanding Where We Wish to Go.” The arrows in the schematic represent the notion that the three foci should all equally impact the envisioned 2027 institution. This exercise was done within each small group and presented to the large group with no group discussion.

Figure 2. Understanding where we wish to go Group 3

Session Three: Critical Action.

Below, I present the results via the discussion regarding the group’s Strategy Building Resource Implementation exercise (Freire, 2016). In the individual focus, looking at the ability to speak up, Nurse K “going back to the article, the courage for nursing to speak up in addressing issues of quality of life. use of a confident voice, Nurse K talked about the ability to speak in and said kind of going back to the article, getting the courage for nursing to speak up about issues of quality of versus quantity of care.” On the opposing view of this the Nurse K goes on to say, “Speaking up can cause fear and then lack of self-esteem enters into it.”

Focusing on organizational foci, Nurse K discussed how sometimes there is some confusion about palliative care versus hospice and suggests “perhaps we should change
the name of the palliative care team to goals of care team.” From an institutional focus,

Nurse K goes on to suggest “When the patients come from the nursing homes to the hospital and they are a DNR, sometimes the doctors are hesitant to change that” going on “If we could find a way to sustain that so there is not break in that process.”

Governmental focus from the group came in the example of “The idea of a national health service where you can make everything more transparent.”

Table 2

*Strategy Building, Planning, Resource-Acquisition, Implementation Group 3.*

<table>
<thead>
<tr>
<th>FOR</th>
<th>AGAINST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals</strong></td>
<td>Courage to speak up</td>
</tr>
<tr>
<td></td>
<td>Quality versus length of life</td>
</tr>
<tr>
<td></td>
<td>Dignity in dying for all ages</td>
</tr>
<tr>
<td><strong>Organizations</strong></td>
<td>Goals of Care Team for Chronic Illnesses could work</td>
</tr>
<tr>
<td></td>
<td>Done on admission a scoring system for automatic Palliative Care Consult</td>
</tr>
<tr>
<td><strong>Institutions</strong></td>
<td>Code status sustained across episodes of care (Nursing Home- Hospital Physician Education of Palliative Care)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Government</strong></td>
<td>Care everywhere in all systems (from hospital to hospital and across networks)</td>
</tr>
</tbody>
</table>

Below, I present the results via the discussion regarding the groups’ Action Project
Exercise (Freire, 2016). This group came up with two separate projects, the Pollyanna Project and the Palliative Care Scoring System. Regarding the Pollyanna Project, as one member of Group 3 said, “What it of this.”

does is address lateral violence, and the point of it is to respond to negative comment with a positive one.” To explain more, “It addresses that you are not going to be a part of lateral violence, you know, you are going to stand alone, and you are not going to partake in it.”

The nurse went on to explain “It goes across other departments; families, physicians, and co-workers.” For the second project, Palliative Care Scoring System, Nurse K explained “Having a palliative care scoring system would be beneficial for the team and promote empowerment for the family and patient.” She goes on to explain, “With the early notification, we could promote early education and that empowers us.” Adding “It would help ease the burden for the nurse on some

Table 3

*Group 3 Action Project.*

<table>
<thead>
<tr>
<th>WHAT</th>
<th>The Pollyanna Project is an attempt at redirecting negative behavior such as gossip or undermining in nurses that stem from oppressed group behaviors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHY</td>
<td>To stop gossiping and undermining behavior; to encourage people instead of discourage people; to reduce lateral violence; to change perceptions and view people in a positive way.</td>
</tr>
<tr>
<td>WHEN</td>
<td>At work, any situation.</td>
</tr>
<tr>
<td>WHERE</td>
<td>Everywhere</td>
</tr>
<tr>
<td>HOW</td>
<td>Teaching nurses to respond to gossip or negative comments by replying “and the positive comment is..” as a way to redirecting this behavior. The hope is that this will defuse this behavior and decrease stress</td>
</tr>
<tr>
<td>WHAT</td>
<td>Palliative Consult Scoring System is an automated process set up in the electronic medical record that allows nurses to score patients on admission based on criteria to automatically ask for palliative care consult</td>
</tr>
<tr>
<td>WHY</td>
<td>To help impact timely palliative care consults; to improve the</td>
</tr>
</tbody>
</table>
standard for quality and ethical care for patients who would benefit from palliative care; to assist the patient and family in planning clear goals.

<table>
<thead>
<tr>
<th>WHEN</th>
<th>On admission, or within first 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHERE</td>
<td>Patient’s electronic health record.</td>
</tr>
<tr>
<td>HOW</td>
<td>Scoring system on recent admission or chronic health illness</td>
</tr>
</tbody>
</table>
REFERENCES


and possible pitfalls of his educational approach. *Community Development Journal*, 35(1), 3-15. [http://dx.doi.org/10.1093/cdj/35.1.3](http://dx.doi.org/10.1093/cdj/35.1.3)

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., ………


http://dx.doi.org/10.1080/15265161.2016.1239782

Canadian Nurses Association Code of Ethics for Registered Nurses (2017). (pp. 6, 34).  
Retrieved from http://www.cna-aiic.ca/ethics


http://dx.doi.org/10.1016/j.outlook.2015.11.008

http://dx.doi.org/10.1097/ANC.0b013e3181dd6c48

http://dx.doi.org/10.3928/01484834-20130319-01


http://dx.doi.org/10.1037/0021-9010.78.1.98


Cudd, A. E. (01/01/2006). *Analyzing oppression* https://doi.org/10.1093

/Dai517431.001.0001


Retrieved from https://monoskop.org>images>Foucalt_Michel_Discipline_and Punish


Freire Institute (2016). *Paulo Freire workshop: The learning process.* © Unpublished internal document. Freire Institute, University of Central Lancashire, Burnley, UK


http://dx.doi.org/10.1191/0969733002ne522oa


http://dx.doi.org/10.1016/j.socscimed.2017.02.029


http://dx.doi.org/10.1097/00003465-200509000-00011


Henrich, N. J., Dodek, P. M., Gladstone, E., Alden, L., Keenan, Reynolds, S., &
[dx.doi.org/10.4037/ajcc2017786](http://dx.doi.org/10.4037/ajcc2017786)


https://www.researchgate.net/publication/262178931


263


Mantzoukos, S. (2005). The inclusion of bias in reflective and reflexive
http://dx.doi.org/10.1177/174498710501000305


http://dx.doi.org/10.1177/0969733014557139


Parthemore, J., & Whitby, B. (2014). Moral agency, moral responsibility, and artifacts: What existing artifacts fail to achieve (and why), and why they, nevertheless, can (and do) make moral claims upon us. *International Journal of Machine Consciousness, 6*(2), 141-161. [http://dx.doi.org/10.1142/S1793843014400162](http://dx.doi.org/10.1142/S1793843014400162)


http://dx.doi.org/10.1097/ANS.0000000000000004


http://dx.doi.org/10.1111/j.1365-2648.2004.03008.x


https://doi.org/10.1378/chest.14-0256


Rodwell, J., & Demir, D. (2012). Oppression and exposure as differentiating predictors


Sullivan, G.M., & Feinn, R. (2012). Using effect size—or why the p-value is not enough. *Journal of Graduate Medical Education, September*, 279-282. [http://dx.doi.org/10.4300/JGME-D-12-00156.1](http://dx.doi.org/10.4300/JGME-D-12-00156.1)


[http://dx.doi.org/10.1177/1757975914532505](http://dx.doi.org/10.1177/1757975914532505)


Wilkie, A. (August 26, 2015). *Improve your research technique: Reflexive thinking, 5 important tips.* Retrieved from https://www.cxpartners.co.uk/our-thinking/improve-your-research-tech


Vita

Nancy Bevan graduated from the University of Cincinnati with a Bachelor’s Degree in Nursing and Science in 1980, and a Master’s Degree in Nursing in 1988. She has practiced nursing in a number of cities ranging from the New Jersey, Chicago and Cincinnati. Practicing as first a clinical nurse, and then advanced practice nurse in critical care, she always had an intense interest in nursing research, particularly on how is affected nurses in clinical practice. Nancy has published a number of articles in her career ranging on topics of unilateral lung disease to running a successful nursing research council. She had been a research mentor to nurses in a number of hospitals, having served as the chair of a number of nursing research councils in different hospitals. She was also instrumental in helping her hospital achieve exemplary status in research and evidence-based practice in a Magnet Recognition Program by building a research division. Nancy also served as the primary investigator on four nursing research studies while working and has served on several institutional review boards. Having been an advanced practice nurse for 25 years, she also functioned as an adjunct faculty member in the MSN program. Nancy has also done poster presentations and podium presentations at national and international conferences numerous times in her career. She decided to take the plunge later time in her life and complete her PhD in Nursing to further her ability to conduct nursing research. While at UMKC Nancy was selected as a Jonas Nurse Scholar for 2014- 2016 cohort.