

Potential Erosion of Ethical Sentiments: When Nurse, Patient and Institution Collide

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Abstract

Introduction: Moral distress occurs when a nurse feels certain what course of action should be taken but is constrained from following that course. Nurses' moral distress may arise from conflicts between the nurse's personal values and institutional requirements, decisions of team members, patients, or their surrogates. Nurses feel frustration, guilt, and anger nurses in such conflicts that can result in burnout and erosion of ethical sentiment leading to avoiding patient contact, changing positions and leaving the profession.

Method: A literature review identified research and theoretical articles related to moral distress in nurses.

Findings: Moral distress is a common experience for nurses with long-term effects on nurses' lives and patient care. Internal and external constraints impede nurses' moral action.

Discussion and Implications: Policy makers, educators, and institutions should implement programs and support systems to better prepare nurses to build up moral courage, negotiate ethical situations and manage ensuing moral distress in order to improve their own wellbeing and that of their patients.

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The current economic climate has mitigated, to some extent, the worldwide nursing shortage as nurses have increased work hours to supplement lost income. As the economy recovers, it is likely the nursing shortage will resurge. This is due in part to the aging nursing workforce, the aging baby boomer generation requiring more medical care and improvements in healthcare and living conditions resulting in longer lifespan for all. Thus, as the nursing workforces ages and retires, the need for nurses will increase.

Although there are differences in the worldwide distribution of healthcare providers, in developed countries, nurses are the most numerous providers of healthcare. Nurses spend more time with patients than any other healthcare providers. Inpatient settings such as hospitals and long-term care facilities need nurses 24 hours a day, 365 days a year, so nursing shortages can have a significant effect on patient outcomes. Unfortunately, there is evidence nurses are not satisfied with their working conditions, leading to turnover and nurses leaving the profession. Reported sources of nurse dissatisfaction included inadequate staffing, heavy workloads, increased overtime, lack of sufficient support staff, and moral distress (Corley 1995; Corley et al. 2001; Morris and Dracup 2008; U. S. GAO 2001). Nursing is emotional work. The current fast-paced environment with complex treatment for acutely ill patients can make it difficult to "turn on the caring emotion" (Sumner and Townsend-Rocchiccioli 2003 p. 164) and interferes with

nurses' ability to provide the quality care (Nathaniel 2002) perceived by nurses as ideal. These and other matters likely contribute to moral distress.

The literature provides a broad spectrum of reasons nurses experience moral distress beyond workload, including treatment concerns, disagreement between providers about appropriate treatment, and institutional support. Aggressive treatment of terminally ill patients, unnecessary treatment or tests, incompetent or inadequate care by other providers, deception, the power imbalance between professionals, and institutional policies can lead to moral distress in nurses (McCarthy and Deady 2008; Morris and Dracup 2008). Nurses also reported distress when patients and families made decisions that conflicted with nurses' personal values and when families refuse necessary care or choose treatment nurses believe is inappropriate or potentially harmful (Curl 2009; Ondeck 2009)

Several researchers have shown that moral distress leads to burnout (Fry et al. 2002; Meltzer and Huckabay 2004; Rice et al. 2008) defined as a syndrome of fatigue, reduced personal accomplishment, depersonalization, cynicism and emotional exhaustion (Maslach et al. 2001). Because of moral distress, nurses may change employment (Corley et al. 2001; Corley et al. 2005), leading to economic and experience loss for facilities and compromising remuneration such as accrual of retirement benefits for nurses. Many nurses accept new employment within nursing, but others leave the profession altogether (Kelly 1998; Wilkinson 1987-88).

Experiences of moral distress may also have implications beyond job dissatisfaction and turnover (Elpern et al. 2009). Research and anecdotal evidence indicates nurses may not readily "shrug off" incidences of moral distress. Rather moral distress may require considerable time to reconcile (Fenton, 1988) and leads to long term physical and psychological problems affecting nurses' personal and professional lives (Morris and Dracup, 2008). In fact, in a review of five studies of nurses' moral distress, nurse reported positive resolution only 25% of the time, leaving them to choose between coping with the situation or leaving the work setting the other 75% of the time (Redman and Fry 2000). In this paper, we focus on the experience of moral distress in nurses and the potential erosion of ethical sentiments in nurses who experience moral distress.

Methods

A database search of Medline, CINAHL and PsychLit using the terms moral distress, ethical distress, and nurse burnout revealed 23 articles related to the topic of moral distress in nursing. References of the articles were searched and 18 additional articles were identified.

Review of the Literature

Theoretical Definitions

In nursing, the term moral distress became popular when Jameton (1984) noted the term "moral dilemma" did not fit the stories many nurses tell. In a moral dilemma, there is uncertainty about the best action. In contrast, nurses tell stories of suffering and their beliefs about the significance of the situations, indicating nurses know what should be done (Jameton 1993). Hence, Jameton defined moral distress as arising when "one knows the right thing to do, but institutional

constraints make it nearly impossible to pursue the right course of action" (1984, p. 6). Wilkinson (1987-88) further specified moral distress in nurses occurs when their actions violate their personal beliefs.

Fenton (1988) identified the feeling tone of moral distress as a "disturbing emotional response" (1988, p. 8) with psychological disequilibrium and a negative feeling state. Nathaniel (2002) expanded this description:

Moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing (paragraph 5).

This dramatic description of nurses' experience with moral distress is important in understanding the experience of nurses. At the heart of moral distress are the values and beliefs of the nurse. Nursing education focuses on a code of ethics and exposes students to values clarification activities and analyses of ethical dilemmas. Nurses expect to be able to practice ethically. Yet nurses must carry out treatment they do not agree with or not implement treatment they believe is in the best interests of the patient because of the decisions of the patient, the patient's surrogate, other providers or the institution.

Repenshek (2009) argued Jameton's (1984) definition of moral distress has been co-opted by the anger and frustration felt by nurses during end-of-life decision-making, a time when certainty, the linchpin of Jameton's definition, rarely exists. However, this clarification does not change the distress nurses feel when these decisions are made. It is the very essence of subjectivity that makes moral action or non-action distressing.

Moral distress in nurses has been examined using both qualitative and quantitative research methods. Most of the researchers studied the types of cases nurses encountered that caused moral distress as well as the intensity, frequency, and complexity of their distress. Other researchers have explored the emotional and physical effects of moral distress on nurses and identified its effects on nurses' personal lives, their patient care, and their decisions to change nursing positions or leave the profession altogether. Some researchers have explored the relationship between moral distress and nurses' demographics and environmental milieu. In all of these studies, the waning of ethical sentiment is clearly present.

Review of Studies

At least ten published studies have used Corley's Moral Distress Scale (MDS) or a variation of the scale (Corley 1995; Corley et al. 2001; 2005; Elpern et al. 2009; Hamric and Blackhall 2007; Meltzer and Huckabay 2004; Mobley et al. 2007; Pauly et al. 2009; Rice et al. 2008; Zuzelo 2007). Originally a 32-item Likert scale to measure frequency and intensity of moral distress in nurses, the MDS was later modified and expanded to 38 items and the scale was adjusted from 1-7 to 0 to 6. The tool lists 38 ethical situations to which the participant ranks both frequency and intensity on a Likert scale. Cronbach's alpha is reported as .98 for the intensity scale and .90 for

the frequency scale of the revised tool. Hamric revised the tool to include physician providers and this has been used in at least two studies, one of which is not yet published (Hamric, personal communication, Winland-Brown,). Table 1 provides information on methods, study participants and tools used for the various studies cited. The review covers types and complexity of cases, related variable, effects of moral distress on nurses' personal and professional lives, coping with moral distress, and effects on patient care.

Types and complexity of cases. Table 2 provides the most frequently cited case experiences identified by study participants. Some fit more than one category. For instance, continuing care when it is not in the best interest of the patient falls in both the futile/overly aggressive treatment category and inappropriate use of resources.

In at least one study of critical care nurses, futile care was the most frequently cited case (Mobley et al. 2007). Futile care was among the most frequently cited case types in four other studies (Gutierrez 2005; Hamric and Blackhall 2007; Pauly et al. 2009; Redman and Fry 2000). In studies of nurses across specialties, the most frequently reported case was 'working with unsafe staffing levels' (Corley et al. 2001; 2005; Hamric and Blackhall; Redman and Fry; Pauly). Contextually, unsafe staffing is not just about the number of nurses; but also the nurses' ability, knowledge, and skill to care for the patients they are assigned. This may occur when nurses are new or replaced by nurses from outside agencies or other units in the facility.

Complexity refers to the number of moral issues involved in individual cases. Gutierrez (2005) asked 12 nurses to relate just one experience in which they felt moral distress. The 12 resulting cases averaged three moral issues per case with the range of issues from 1-6. In another qualitative study with relatively new nurses, Kelly (1998) found participants experienced high levels of moral distress when they felt a need to subvert their own personal standards for good care based on the care expectations of multiple other providers that were different from their own.

Intensity and frequency of moral distress. Nurses in most studies reported moderate to high levels of distressing cases (Corley 1995; Corley et al. 2001; 2005; Elpern et al. 2009; Gutierrez 2005; Hamric and Blackhall 2007; Meltzer and Huckabay 2004; Mobley et al. 2007; Pauly et al. 2009; Rice et al. 2008; Zuzelo 2007). Researchers focused exclusively on critical care nurses reported higher levels of moral distress than researchers who studied nurses from across specialties (Elpern; Gutierrez 2005; Hamric and Blackhall; Meltzer and Huckabay; Mobley). Mobley collapsed the individual items of the MDS into six categories: physician practice, nursing practice, institutional factors, futile care, deception, and euthanasia. Intensity was high in all six categories for these critical care nurses. In Corley's (1995) critical care nurses working in non-critical environments experienced higher distress for aggressive care than nurses working in critical care units did. In a qualitative study, nurses who assisted with elective abortions suggested moral distress increased in intensity with repeated experiences (Hanna 2005).

Generally, in studies using the MDS, intensity of moral distress was higher than frequency (Corley et al. 2001; 2005; Pauly et al.; 2009 Rice et al. 2008). This suggests nurses may not experience moral distress often, but it is severe when they do. However, in a qualitative study, 24 nurses reported frequent experiences of moral distress with a total of 72 cases for an

average of three cases per participant. All but one described experiencing moral distress at least once a week. Cases included harm to patients, needless pain and suffering, dehumanization of patients, deception, unnecessary treatment, prolonging life and inadequate care by a physician (Wilkinson 1987-88). Similarly, Gutierrez's (2005) 12 critical care nurse participants reported 40 episodes of moral distress, averaging more than 3 episodes per participant. In Corley et al.'s 2001 study, the item with the highest intensity, "work with unsafe levels of staff" also had the highest frequency.

Related Variables. The type of nursing work, ethical work environment, and demographic characteristics may influence moral distress. We have already presented some evidence that different types of nursing are more likely to cause moral distress, specifically critical care (Elpern et al. 2009; Gutierrez 2005; Hamric and Blackhall 2005; Meltzer and Huckabay 2004; Mobley et al. 2007) and elective abortion (Hanna 2005). However, there are many specialties in nursing, each presenting unique moral situations. In a review of studies across specialties, Redman and Fry (2000) found pediatric nurses were most concerned about child/parent/practitioner relationships; dialysis nurses were distressed over decisions regarding initiation or discontinuation of treatment; rehabilitation nurses cited under or over treatment and not meeting the standard of care. Diabetic educators found disagreement with the quality of medical care provided, and administrators cited inadequate resources for quality care. Additionally, nurses in private hospitals reported significantly greater moral distress than nurses working in a medical center did (Corley 1995). Finally, ethical work environment can be predictive of moral distress intensity in nurses (Corley et al. 2005; Hamric and Blackhall 2005).

Several studies reported no relationship with personal demographics of nurse participants, but some correlations are suggested. For example, Elpern et al. (2009) found age positively correlated with moral distress, but Corley et al. (2005) found a negative correlation between these variables. Corley et al. (2005) also found a difference in moral distress by ethnicity, with African American nurses experiencing higher intensity of moral distress than other ethnic groups. Mobley et al. (2007) found distress related to futile care significantly related to age >33, time in critical care and nursing practice >7 years. Meltzer and Huckabay (2004) found nurses with baccalaureate degrees experienced more painful feelings related to moral distress than did nurses with an associate degree. These same researchers found nurses who considered religion unimportant in their lives scored higher on the emotional exhaustion subscale of the Maslach Burnout Inventory compared to nurses who reported religion as important in their lives. In this same study, younger nurses reported more feelings of depersonalization than older nurses did.

Effects on Nurses' Personal and Professional Lives

Qualitative studies provide compelling evidence of the effects of moral distress on nurses' lives. Qualitative data captured a description of the experience, the relationship of nurses' personal values to moral distress, their coping efforts, the frequency of distress, cases that caused distress,

the nurses' emotions, the context of the case, and effects on their personal wholeness, relationships, coping behaviors and patient care.

Hanna (2005) is the only researcher who explored the components of the moral distress. The components of moral distress include the type of situation, the response intensity, the frequency with which the nurse encounters the situation, the duration and the acuteness of pain, as manifested by shock, numbness, fight or flight, or other physical or emotional symptoms. Closer proximity to the event and actually being present at the time perceived harm occurs evokes a greater response than participating distantly or just hearing about the event.

Personal values and moral distress. Hanna (2005) used survey and qualitative data to examine the experience of nurses who participated in elective abortion. Nurses reported distress from having to choose between their personal and nursing values. Nurses who participated in abortions found it challenged their personal beliefs, either past or current. Some comments showing their inner conflict include “personal beliefs are overshadowed by professional commitment,” and conversely, “nursing duties stop when moral values pick up” (p. 103).

In Wilkinson's (1987-88) study, with the exception of lying, which participants said was always wrong, judgment about cases depended more on their personal beliefs regarding quality of life, euthanasia and letting patients die than on what was actually done. Nurses felt pressured to act or not act by society, nurse education, and peers (Hanna 2005; Holly 1993; Kelly 1998; Zuzelo 2007). Nurses who participated in abortions were especially distressed when they had counseled the woman in family planning or when they learned a significant other had coerced the woman to have the abortion. In the later cases, nurses reported having felt they had not only harmed the fetus but had added harm to the woman (Hanna 2005).

Physical, emotional, and social sequelae to moral distress. Reported physical symptoms of moral distress included heart palpitation, diarrhea (Wilkinson 1987-88), headaches (Wilkinson 1987-88; Gutierrez 2005; Hanna 2005) nausea (Hanna 2005), and fatigue (Hanna; Gutierrez). Neck, muscle and stomach pain as well as sleep dysfunction were also reported (Gutierrez).

Anger, frustration and guilt were the nurses' most common emotional responses to moral distress (Holly 1993; Gutierrez 2005; Wilkinson 1987-88; Zuzelo 2007) and nurses reported being laden with self-criticism and self-blame (Kelly 1998). Some described anguish and powerlessness (Holly 1993). Nurses dreamed about work and had nightmares (Gutierrez 2005). Some reported feeling depressed when they had to go to work (Wilkinson 1987-88). Nurses' emotional burden is displayed in their comments. One said, “I often equate my job with ‘keeping dead people alive’. On these days, I dread coming to work” (Elpern et al. 2009 p. 525). Another said, “I'm scared that I'm causing undue pain and suffering, and this causes me great distress” (p 527).

Nurses reported moral distress affected personal relationships because they could not “turn off” the distress when they went home and found themselves crying and feeling dysfunctional at home (Wilkinson 1987-88, Gutierrez 2005.) Some talked to their families and friends about their experiences, feelings and concerns. They encouraged family to complete

living wills and advanced directives (Elpern et al. 2009; Gutierrez). They refused to donate organs (Gutierrez; Elpern et al. 2009) or blood (Elpern) or allow family members to do so. Some nurses, however, actually physically withdrew from family members and friends (Gutierrez).

Coping with Moral Distress

As cited above, some nurses talked to other nurses, family and friends (Gutierrez 2005). However, some nurses muted their distress, not talking to others. Rather they carried on internal conversations to resolve feelings and reconcile to the experience (Hanna 2005; Kelly, 1998).

Hanna's (2005) participants graphically related how they reacted and coped. Coping depended on situational conditions and qualities of an individual's coping skills. Nurses described collapsing on the utility room floor, crying in their office or a bathroom, avoiding talking to others but holding long conversation with self, taking long walks and reflecting. Nurses who were able to use reflection as a coping mechanism did not quit their jobs, but decided against future involvement in distressing situations or set limits on their involvement. Some used alcohol, drugs or other escapes. Some reported being able to deny, suppress, or ignore their inner dialogues.

It is of particular concern that some nurses were unwilling to tell anyone about their experiences for fear of judgment from others who might not understand (Hanna 2005; Kelly 1998). Other nurses reported blocking or suppressing their thoughts and feelings resulting in dulling of their ability to assess their own state. Nurses also reported highly frequent experiences with moral distress blocked their ability to reflect consciously on their experiences (Hanna). In one study, "a number of nurses indicated that they had worried that their personal experiences of distress were unique and disproportionate to what other nurses experienced" (Elpern et al. 2009 p.530). Despite study participants relating feeling of guilt, frustration, and anger, some nurses were able to eschew guilt because the physicians made the decision and they were only following orders (Wilkinson, 87-88). Kelly's (1998) research helps us to understand how new nurses, steeped in a desire to relieve suffering and do good, can fail to take moral actions when confronted with the realities of practice.

I put too much pressure on myself. I am not condoning the kind of care I give, and if we had more staff, I would provide the kind of care I believe should be given. To be the kind of nurse I want to be causes all kinds of frustrations. I went through burnout because of it. I was just going through the motions. Just giving physical care. Very short with patients. Some I avoided because of the frustration. I just didn't have the motivation (Kelly 1998 p 1140).

These experiences chip away at nurses' professional self-concept, and nurses' experiences alienation, a discrepancy between internalized aspirations, norms and values and the opportunities to fulfill them (Finifter 1972). Nurses may feel a loss of ideals and turns to rationalization to survive. Rationalization is a form of self-deception in which nurses find justifications for their behaviors to protect themselves from the grief and distress experienced as they realize they are not who they thought they could be (Allport 1982). Finally, nurses integrate

rationalizations into the new self-concept (Kelly 1998). This re-tooled professional image looked this way to one participant:

“I think my main concern has changed from the caring about the patients, which you would never say in school, to really caring about and helping my buddies as best I can. I guess the patient care is the ultimate goal that is why supporting staff is more important because that way they receive help and the patient receives help. I need to survive to take care of patients. Kelly 1998 p.1140.

Resources for Coping. Nearly absent in all of the studies was a discussion of utilization of coping resources provided by employers, religious leaders and others. Gutierrez (2005) reported 67% of the participants said their sole support was other nurses, but the support was for negative feelings only, not helping them to implement moral action. While some reported also talking to friends and families, one-third said they had no support at all (Gutierrez 2005; Zuzelo 2007).

Potential sources of support include supervisors, managers, ethics committees, chaplains, nurse colleagues, risk manager and other care providers (Zuzelo 2007), although Wilkinson (1987-88) reported only three participants felt supported by administration. The research on ethical climate indicated that a positive ethical climate may mitigate some of the distress nurses experience (Corley et al. 2005; Hamric and Blackhall 2007; and Pauly et al. 2009).

Holly (1993) described the barriers as “staggering.” Although ethics committees, administrators and in some cases even counselors are available, the mechanisms are poorly defined and time pressures make it difficult for nurses to connect with someone who might be able to help before the situation plays out. Zuzelo (2007) confirmed some nurses do not know how to access support, and support is generally limited in off hours.

Nurses, as employees, also have security concerns from hierarchic forces of administration and medicine in the institution (Holly 1993) and the hierarchical power structure of health care arose as a barrier in several studies (Gutierrez 2005; Kelly 1998; Redman and Fry 2000; Wilkinson 1987-88). Nurses were wary to initiate consultation with ethics committees because physicians may see it as threatening. Unfortunately, some resigned themselves to the likelihood of malpractice threats and family lawsuits, while their self-expectation was they should be able to handle whatever happened (Elpern et al. 2009).

Although only mentioned in one study of moral distress, there is a long history of gender and class affecting nurse and physician relationships (Coverston, 2001; Gutierrez 2005). The type of hospital can affect how disagreement about treatment plays out. Private hospitals often see physicians as “customers” giving their practice preferences priority over their nurse employees and even over evidence based practices. This can lead to an administration disinclined to confront physicians (Redman and Fry 2000). In addition, nurses are conditioned to “get along” with others. After all, most nurses choose nursing because they want to help others (Coverston). Therefore, nurses may want to appear unified with a physician on a decision even though they do not agree. This may be associated with nurses’ reluctance to distress patients’ families; however, it may also demonstrate nurse apathy or fear of reprisal (Gutierrez).

Conflict can arise between providers due to differing professional philosophical orientation, as the physician orientation to saving lives and the nurse orientation to relieving suffering. The philosophical differences may affect defining adequacy of care, physicians' respect or lack of respect for nurses' expertise and knowledge, and may create difficulty in actually performing the nursing role as advocate for the patient (Redman and Fry 2000). It can also happen that family members and community members have disparate goals to those of the providers or even the patient (Redman and Fry).

Probably one of the greatest barriers to resolutions of ethical situations is communication, which is ineffective, inaccurate, or incomplete. This may be nurse and/ or physician to patients and family, lack of assertiveness by the nurse, the nurse not being included in the discussion, time limitations where a decision must be made without all pertinent information, and the nurse's lack of follow-up with family or the physician (Gutierrez 2005).

Effects on Nurses' Work and Patient Care

Some positive effects arose from nurses' experiences with moral distress. Some nurses reported an interest in ethics, increased desire to advocate for patients, and enhanced relationships with other nurses (Gutierrez 2005). Nurses were particularly willing to get involved when comfort or patient rights were at stake (Holly 1993). Nurses found introspection and reflection helpful in reconciling their experiences (Gutierrez; Holly 1993; Kelly 1998).

Of special interest to those responsible for health care systems is the effect of moral distress on patient care. Some of the same nurses cited as having positive responses to moral distress also reported reluctance to go to work or care for patients, and experienced emotional and physical withdrawal from others, not just at the hospital but in other situations as well. They questioned their role, quality of care given by nurses, and the appropriateness of care. They were hesitant to become primary nurses for patients and refused to participate in work-related committees. They also considered leaving their position or nursing altogether (Gutierrez 2005).

Although nurses in one study, perhaps unable to tamper with their self-image as good nurses, reported their care for patients had not changed because of moral distress. However, after further interview, they reported coping by avoiding patients or particular job situations. When those coping behaviors were unsuccessful, they changed jobs or left nursing all together (Wilkinson 1987-88). Similarly, when Gutierrez (2005) asked nurses about effects of moral distress on patient care, the nurses denied any effect. However, as the interviews continued, more than half disclosed requesting to not care for particular patients and a third of them identified decreased interactions with both patients and their families. They reported distancing themselves emotionally and admitted providing less personalized care and providing care with decreased frequency.

Nurses' inability to act in accordance with their conscience likely contributes to the high turnover in nursing (Holly 1993). Nurses have reported changing jobs and leaving nursing altogether because of moral distress (Corley 1995; Corley et al. 2001) Corley et al. (2001) reported 15% (23) of the 158 nurse respondents had left a position because of moral distress. In a

2001 report, the rate was 13% (Corley et al.). In a two-site study, nurses and physicians reported similar intensity of moral distress, but nurses experienced a much higher frequency of moral distress than physicians did. At site one, 23% of the nurses had considered leaving. At site two 17% of the nurse respondents had left a position because of distress and another 28% had considered leaving, nearly half the respondents at that site. Only one physician considered resigning due to moral distress (Hamric and Blackhall 2007).

Discussion and Implications for Health Care Administrators, Educators and Policymakers

“No one really helps nurses. We live with this day in and day out. No therapy. No intervention. Nothing. We just go on to the next patient” (Elpern et al. p. 528).

The above quote poignantly reflects the significance of moral distress in nursing. This intense moral distress can actually compromise nurses’ health and well-being and may be hazardous to not only the nurses but patients and their families.

Morris and Dracup (2008) concluded frequent interactions with families who demand care for critically ill loved ones providers view as futile “represents a significant health hazard for health care professionals, particularly nurses providing direct patient care” (p. 399). There is also evidence that nurses’ moral distress has negative effects on health care systems manifested as burnout, turnover, and compromised patient care (Bell & Breslin 2008; Beumer 2008). Hospital administrators and policy makers must acknowledge the moral burden of nurses and commit to helping them manage the associated psychological disequilibrium and develop effective guidelines and policies to help nurses when they encounter ethical dilemmas (AACN, *position statement*; Pendry 2007).

Fortunately, the literature provides suggestions that can help nurses, health care organizations and policymakers deal with moral distress. These include strategies to help nurses effectively manage ethical situations and moral distress, strategies to improve interdisciplinary relationships, and the participation of bedside nurses in ethics committees. Finally, nursing education both before and after licensure must help nurses gain moral courage to act on behalf of themselves and their patients.

Interventions to help nurses effectively manage ethical situations and moral distress. Ethics education is a critical intervention to help nurses manage ethical situations, improve their job satisfaction, and stay in their current employment (Bell & Breslin 2008; Pauly et al. 2009; Pendry 2007). As teachers of ethics, we tell our students in their first ethics class period that nurses are often involved in ethical situations but not included in the decision-making largely because nurses are not familiar with the language of ethics. Ethics education provides a shared language to enhance clarity during interdisciplinary discussion of moral issues (Gutierrez 2005).

Although nursing curricula, in the United States at least, requires ethics education, too often the classes focus only on ethical principles only and do not prepare students to cope with the realities of practice (Benner et al. 1996; Corley 2002; Kelly 1998). New nurses need to learn to manage the real work environment in an ethical context (Corley). Because nurses often do not acknowledge moral distress in themselves, it is important to help them identify the feelings they experience (stress, emotional exhaustion, burnout, and dissatisfaction with employment) as

symptoms of moral distress (AACN, 2008; Beumer 2007; Pendry 2007). They need to be able to identify and name their feelings as well as learn effective ways to prevent or manage moral distress, which can only be learned through experience (Corley, Benner et al 1996).

Several ways to deliver ethics education in the workplace have been explored. In one study, Beumer (2008) conducted a series of five workshops on ethics for intensive care nurses that successfully decreased nurses' experiences with moral distress. Although workshops can be cost prohibitive, less expensive education can be provided with pamphlets, newsletters, ethics content during orientation, and periodic presentations on coping with moral distress offered by hospital ethics committees or other qualified professionals (Pendry 2007). Ethics education should include familiarizing nurses with available resources to identify and address moral distress, such as AACN's internet resource, *4A's To Rise Above Moral Distress* (Wavra, 2004).

Orientation of newly graduated nurses should include help with handling ethical situations and moral distress (Pendry 2007). For them, moral distress may begin with not being able to "keep up" with other team members, detracting from their professional self-concept (Kelly 1998). This requires mentors who are sensitive to the potential damage to the self-image of new nurses and patient-related distress experienced by more seasoned nurses as well. Effective mentors who have had ethics education will be able to help both themselves and new nurses to manage ethical situations and moral distress more effectively. Extending the length of time new hires spend with mentors would provide opportunities for new hires to gain experience dealing with ethical situations before they are on their own (Pendry 2007).

Seasoned nurses also need support to cope with ethical situations and moral distress. One way is to provide forums for nurses to discuss their experiences. Such discussions help nurses feel they are not alone and may relieve moral distress (Elpern et al., 2005; Pendry 2007). Especially when sessions guided by professional counselors, discussions of moral distress can effectively help nurses and other health care providers recognize and handle moral distress.

Debriefing sessions held after critical events and led by counselors are important opportunities to diffuse moral distress and can include educational components (Bell & Breslin, 2008). Understanding the components of moral distress as described by Hanna (2005) can be helpful in debriefing nurses experiencing moral distress.

To enhance communication with management and administration's awareness of the ethical climate on the nursing units, nurses in charge of units should convey information about moral distress to administration (Gutierrez 2005). It is vital that such efforts take place within a safe culture of identifying and correcting problems rather than a culture of stigmatizing and blaming (Lowe 2010).

Ombudsmen, individuals hired to investigate and help solve problems, can play a role in enhancing a safe, ethical climate in an organization. For example, at Dana-Farber Cancer Institute in Boston, three ombudsmen were appointed to counsel employees on how to report ethical and safety problems. Employees who choose not to report directly receive anonymity while trends in ethical concerns are reported to the chief executive officer (Lowes, 2010).

Strategies to improve interdisciplinary relationships. Improving relationships and collaboration between nurses, physicians, and other health care providers can help alleviate moral distress in nurses. Efforts toward this end can be built into retention and recruitment efforts (Liaschenko 1995; Pauly et al. 2009; Pendry 2007). Physicians may be unaware of the depth of moral distress nurses experience; efforts to address this deficit are needed. Broad changes that may lead to better collaboration and communication include implementation of structured communication protocols, patient care conferences, and open group discussion of issues (Rice et al. 2008). Adoption of evidence-based care protocols can decrease stress on units as they diminish disagreement about patient care during stressful times (Golee 2009).

Nurses should be supported and encouraged to communicate the effects of ethical conflict with physicians. A counselor or facilitator could guide an interdisciplinary forum, in which differing opinions are respectfully discussed (AACN, *position statement*; Gutierrez 2005). Interdisciplinary ethics rounds could be scheduled at regular intervals to discuss ethical dilemmas, care plans, and treatment goals with explanations required for deviations from the standard of care (Golee 2009; Gutierrez 2005). Nevertheless, a spirit of compromise may be needed during interdisciplinary decision-making about ethical issues, and collaboration with families is essential to resolve disagreements and pursue long-term goals (& Baylis 2000).

Another way to enhance collaboration about ethical issues in healthcare is to bring nursing and medical students together for ethical discussions. At least one university has done just that. Nursing and medical students and their faculty facilitators at the University of Minnesota regularly meet to discuss hypothetical clinical situations involving moral conflict and collaborate to resolve issues (Gutierrez 2005). Establishing collaborative habits early may enhance the ethical climate of healthcare in the future.

Participation in ethics committees by nurses who care for patients. Most major healthcare facilities have ethics committees. These committees review cases and develop plans to handle similar situations in the future. It is essential for every ethics committee to include nurses who provide direct patient care. Front line nurses have an unobstructed view of ethical situations that arise in healthcare, and their voices need to be heard. While not every nurse can be on an ethics committee, policies need to guarantee ready access to ethics committees for all nurses whenever needed (AACN 2008)

Cases that frequently cause moral distress, like those discussed in this review, deserve the careful attention of ethics committees. For example, futile care causes a good deal of ethical distress in nurses. Ethics committees can help establish guidelines and policies regarding futile care that can direct practice and diminish moral distress (AACN 2008; Gutierrez 2005; Meltzer and Huckabay 2004).

Developing moral courage in nurses. The elephant in the room is how do we help nurses, who have a strong ethical sense, take moral action? The research clearly indicates the burden of constraints felt by nurses young and old. Breaking down those constraints can certainly help, but what is moral courage, what does it look like and how can nurses get it?

Perhaps we can learn from those who have exhibited moral courage in their lives to help nurses to retool their self-image to what they thought they could be. A study of moral courage reported exemplars of moral courage were not always successful in attaining their goals. As do nurses who desire the best possible care for their patients, exemplars of moral courage also

experience defeat. However, when something is not working, moral exemplars do not quit, but transform their goals to give new life to their commitments. It is an old truism that in order to conserve something of value, it must move forward. Jean Piaget said it this way: “Swimming is a more viable means of staying afloat than treading water” (as cited in Colby and Damon 1992 p. 340). Nurses who learn to “swim”, i.e. “swim” forward rather than “tread water”, reframe, and reflect on their experiences, adjusting their personal goals for moral action and may become more successful in addressing ethical situations and moral distress.

Surprisingly, although we often think of moral exemplars as ones who act alone, the historical evidence is they do not. Moral exemplars share their intimate thoughts and feelings with close associates as did some of the nurses in the studies. Conversations with intimate colleagues who can prod, challenge, share information, ask questions and give feedback can move one’s moral commitment forward (Colby and Damon, 1992).

Moral courage is not about *knowing* the right thing to do; it is about *doing* the right thing. Ethics education for nurses must contain components that address moral courage directly. This could be done through role play, analyzing how students have approached personal moral dilemmas, and thinking through all possible outcomes of a situation for all stakeholders, including the nurse. Identifying small acts of moral courage in one’s life and identifying barriers to doing the right thing may strengthen resolve to be courageous in more intimidating situations.

Conclusion

It is somewhat ironic that nursing is ranked repeatedly as the most ethical profession (Gallup 2008), yet it is filled with moral distress. As health care technology advances in an environment of limited financial resources, ethical situations will continue to abound. Increasingly nurses, physicians, patients, and families are asking what *should* we do instead of what *can* we do. Nurses may be concerned about families who insist on heroic levels of care for terminally ill loved ones, or they may experience distress when physicians order painful procedures or tests that make little difference in patient outcomes. These and other ethical situations can lead to moral distress contributing to burnout, costly turnover in nursing positions, and abandonment of the profession compromising patient care.

Health care administrators and policy makers must recognize the moral distress that nurses experience and act to help alleviate this distress. It is to everyone’s advantage for nurses to cope effectively with moral distress. It not only improves nurses’ health and well-being, but in very real ways, it can improve the care they provide. Through educating, mentoring, collaborating across disciplines, and championing nurses who exhibit moral courage, nursing can deservedly maintain its ranking as the most ethical profession.

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Article	Corley, Mary. C. (1995). Moral distress of critical care nurses. <i>American Journal of Critical Care</i> , 4, 280-285.	Corley, Mary et al.2001. Development and Evaluation of a Moral Distress Scale. <i>Journal of Advanced Nursing</i> 33 (2):150-156.	Corley, Mary et al. 2005. Nurse Moral Distress and Ethical Work Environment.” <i>Nursing Ethics</i> 12 (4): 381-390.	Elpern, Ellen et al. 2009. Moral Distress of Staff Nurses in a Medical Intensive Care Unit. <i>American Journal of Critical Care</i> 14 (6): 523-530.	Gutierrez, Karen M. (2005). Critical care nurses' perceptions of and responses to moral distress. <i>Dimensions of Critical Care Nursing</i> , 24, (5) 229-241.
Method	survey	Survey	survey	Survey	Grounded theory
Subjects	111 nurses 2 hospitals	214 nurses several hospitals	106 2 centers	28 nurses medical ICU	12 CC nurses
Variables	Moral Distress Scale (MDS) frequency and intensity	(MDS) No demo or prof variables related to distress	MDS and Ethical Work Environment Survey relationship	MDS and open ended	Survey to identify frequency and types of situations; Interviews for single cases
Article	Hamric and Blackhall 2007. Nurse-Physician Perspectives on the Care of Dying Patients in Intensive Care Units: Collaboration, Moral Distress, and Ethical Climate. <i>Crit Care Med</i> 35 (2): 422-429.	Hanna, Debra R (2005) The lived experience of moral distress: Nurses who assisted with elective abortions. <i>Research and Theory for Nursing Practice</i> 19 (1) 95 -124.	Holly Cheryl M. (1993). The ethical quandaries of acute care nursing practice. <i>Journal of Professional Nursing</i> 9(2): 110-5.	Kelly, Brigid. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. <i>Journal of Advanced Nursing</i> , 28, 1134-1145	Meltzer, L. S. and Loucine M. Huckabay. 2004. Critical Care Nurses' Perceptions of Futile Care and Its Effects on Burnout. <i>American Journal of Critical Care</i> 13 (3): 202-208.
Method	Survey	Phenomenology	Qualitative	qualitative	Survey
Participants	14 ICUs 2 institutions 29 MDs/196 RNS		22 nurses in 2 nd year of practice		60 critical care nurses
Variables	Ethical environ. Survey/ MDS and open-ended	Interviews	Interviews		MDS and Burnout scale
Article	Mobley, Melinda J., Mohammad Y. Rady, Joseph L. Verheijde, Bhavesh Patel and Joel S. Larson (2007). The relationship between moral distress and perception of futile care in the critical care unit. <i>Intensive and Critical Care Nursing</i> , 23 (5), 256-263.	Pauly, B., Colleen Varcoe, Janet Storch, and Lorelie Newton.2009. Registered Nurses' Perceptions of Moral Distress and Ethical Climate. <i>Nursing Ethics</i> 16 (5): 561-573	Redman, B. K. and Sara T. Fry. 2000. Nurses' Ethical Conflicts: What is Really Known About Them? <i>Nursing Ethics</i> 7 (4): 360-366.	Rice, E. M., Mohamed Y. Rady, Aretta Hamrick, Joseph L. Verheijde, and Debra K. Pendergast. 2008. Determinants of Moral Distress in Medical and Surgical Nurses at an Adult Care Tertiary Care Hospital. <i>Journal of Nursing Management</i> 16: 360-373.	Wilkinson, Judith M. (1987-88). Moral distress in nursing practice: Experience and effect. <i>Nursing Forum</i> , 23(1), 16
Method	MDS to look at futile care in CC	survey	Systematic review	MDS survey	qualitative
Participant	100 CC nurses	374 nurses	5 studies	260 M/S nurses	24 nurses-72 cases

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s					
Variables	MDS and futile care	MDS and Hospital Ethical Climate Survey and open ended		MDS	interviews
Article	Zuzelo, Patti. R. 2007. Exploring the Moral Distress of Registered Nurses. <i>Nursing ethics</i> 14 (3) 344-359				
Method	survey				
Participants	100 nurses from a health care network				
variables	MDS and open ended				

Table 2 Types of Cases sited with citations

Case	Citations
Discontinuation or initiation of care /euthanasia	Redman and Fry 2000; Rice et al. 2008; Mobley et al. 2007; Wilkinson 1987-88
Futile or overly aggressive treatment by MD or family request/prolong dying/unnecessary pain and suffering	Gutierrez 2005; Hamric et al. 2007; Pauly et al. 2009; Mobley et al. 2007;; Redman and Fry 2000; Wilkinson, 1987-88
Inappropriate use of resources	Corley et al. 2001; Gutierrez 2005; Hamric et al. 2007; Pauly et al. 2009; Rice et al. 2008; Wilkinson, 1987-88
Incongruent treatment goals among family members	(Gutierrez 2005; Redman and Fry 2000; Rice et al. 2008
Incongruent treatment goals between providers and family*	Gutierrez 2005; Hamric et al.
Disregarding of patient wishes by providers/ dehumanizing patients*	Gutierrez 2005; Holly 1993; Wilkinson, 1987-88
Deception / Incomplete information given to patients and/or families by providers*	Gutierrez 2005; Redman and Fry 2005; Rice et al. 2008; Wilkinson 1987-88
Not meeting the standard of care / Working with providers not competent for patient needs; Lack of physician follow up	Corley 2001; 2005; Gutierrez 2005; Hamric et al. 2007; Holly 1993; Redman and Fry 2000; Pauly et al. 2009; Wilkinson 1987-88

We have indicated “providers” to include nurses and others; however, the majority of the nurses specifically identified physicians as the providers.