

Nurse-Physician perspectives on moral distress support the need to create a caring ethical work environment

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Abstract

Moral distress is prevalent in the workforce and is one reason why healthcare providers leave their positions. With the graying of healthcare, we can ill afford this practice to continue. A caring and ethical climate must be created that encourages healthcare providers to address situations that concern them and that will retain them in the workforce. The purpose of this study was to compare nurses, nurse practitioners, and physicians' perspectives on moral distress and to ask for individual input on situations that caused them moral distress that continue to bother them even today. Respondents were asked if moral distress ever caused them to leave or consider leaving a position in the past.

Corley's Moral Distress Scale (MDS) for nurses was revised by Hamric to include a nurse survey and parallel physician survey. This revised 21-item questionnaire was used. 201 nurses, nurse practitioners, and physicians completed the questionnaire. Descriptive statistics were used to show participant characteristics with all the variables as well as the numbers of persons choosing the level of distress felt in each situation. Tests of significance were done to assess these relationships. Due to the low numbers of physicians and nurse practitioners responding, all three groups were analyzed as one. The variables of religion, culture, and whether or not the respondent had participated in any formal ethics education in the past were significant. Also significant was their response to the question if they had ever left or considered leaving their position in the past. Strategies are suggested for creating a caring ethical climate that may lessen the moral distress that health care professionals experience that might encourage them to stay in the workforce.

Introduction

Winland-Brown and Dobrin (2009) previously gave four scenarios with ethically challenging situations to physicians and nurses. There were over 100 written comments expressing participants' moral distress. With a growth in ethical awareness nationally, do these healthcare providers have the tools to deal with moral distress or do they leave the profession? This was the impetus for this current study. The goal was to compare nurses', nurse practitioners', and physicians' perspectives on moral distress and to ask for individual input on situations that caused them moral distress that continue to bother them even today. The researchers also wanted to find out if moral distress was significant enough to ever incite the individual to leave a position. If this is the case, healthcare organizations are not doing enough to create caring

environments and ethical climates to encourage experienced workers to stay in the workforce to accomplish the moral work that is so necessary on a daily basis.

While the term mass exit may seem a little extreme, when hospitals and agencies are on bare bones staff, any reduction in workforce is detrimental to an efficient workplace environment. In addition, with the graying of healthcare and professionals nearing retirement and/or dying, who is going to replace the current staff? This is of great concern: who will care for current healthcare workers when they need compassionate care?

Review of Literature

Moral distress

The earliest situation of moral distress can be found in Florence Nightingale's Notes on Nursing (Nightingale 1859/1980). Nightingale describes her insight into the elements that constitute Nursing and describes her frustration when faced with obstacles placed before her, thus hindering the care she wishes to provide. Nightingale's Notes on Nursing exemplify the foundation of all current definitions of moral distress.

Andrew Jameton, a Professor in Public Health at the University of Nebraska Medical Center has done the seminal work on moral distress for over 25 years. He refers to two types of moral distress; initial distress and reactive distress. Initial distress "involves the feelings of frustration, anger, and anxiety that people experience when faced with institutional obstacles and conflicts with others about values" and reactive distress is "the distress that people feel when they do not act upon their initial distress" (Jameton 1993,544).

While some nurses are unable to define moral distress, they actually experience some of the objective symptoms that are related to moral distress- those of stress, burnout, emotional exhaustion, and job dissatisfaction (Pendry 2007). For the purpose of this study, the definition used for moral distress is extreme discomfort in a patient care situation that results when one knows what one ought to do, but because of internal or external constraints, ends up doing what one knows is morally wrong (Corley 2002; Pendry 2007; Badger and O'Connor 2006). The Nursing Diagnosis Group approved moral distress as a new nursing diagnosis for 2007-08 (NANDA 2007-2008).

Varying statistics relate the numbers of RNs who experience moral distress. Corley (2002) found that 80% of RNs have experienced moral distress in the past. Redman and Fry (2000) found that one third of the nurses experienced moral distress in their study. While the majority of the studies relate to moral distress in the nursing profession, it is a growing problem in all health professions. Ulrich, Hamric and Grady (2010) discuss the fact that physicians often witness patient situations where they feel ineffectual. Another study examining both physicians and nurses found that nurses experienced more moral distress than physicians, perceived a more negative ethical environment, and were less satisfied with the quality of care that was provided on their units (Hamric and Blackhall 2007). Researchers from the University of Virginia recently studied ICU physicians and found that while doctors on the average are less frustrated than nurses, they also suffer from intense moral distress (Chen 2009). In a study with both physicians

and nurses, Winland-Brown and Dobrin (2009) found that 34% of the combined physicians and nurses had experienced moral distress in the past.

Moral distress is a significant concern in today's workplace (Zuzelo 2006). The relationship between moral distress and lower nurse satisfaction as well as a decreased quality of care must be dealt with to both prevent nurses from leaving the profession, and maintain quality care. Many nurses experience moral distress when participating in futile care where advanced technology may prolong patients' lives. Burnout which leaves nurses exhausted has been shown to be one reason that nurses feel they cannot continue with their jobs. One study noted 15% of nurses resigned their position due to moral distress (Corley, Elswick, Gorman, and Clor, 2001). Meltzer and Huckabay (2004) explored the relationship between critical care nurses' perceptions of futile care and the effect of futile care on burnout. There was a significant relationship between the morally distressing situations involving futile care and one of the components of burnout- that of emotional exhaustion.

Strategies to create caring environments

In a recent study, the ethical climate and levels of moral distress were significantly correlated (Pauly, Varcoe, Storch and Newton 2009). In another study, Hamric and Blackhall (2007) found that 17% of the RNs had left a position and 28% had considered leaving. RNs with a higher moral distress score were more likely to consider leaving or had left a position than RNs with lower scores. In one Associated Press article titled "Hospitals fight to stop new nurses from quitting", Mankour (2009) cites a study showing that 20% of new nurses leave the profession within a year. With nurse retention related to the ethical climate and moral distress, multiple strategies must be explored and incorporated into the work environment to create caring environments that will enhance the ethical climate in today's workplace.

Religion has been found to help individuals cope with their stressors. This may be because of finding meaning, purpose and hope, which may nurture individuals in their suffering (Baldacchino and Draper 2001,833). Spiritual coping strategies may safeguard the wholeness and integrity of the patients thus facilitating an ethical climate. Meltzer and Huckabay (2004) found that nurses who didn't consider religion to be important in their lives were significantly more emotionally exhausted than nurses who reported that religion was very important in their lives. Emotional exhaustion is one of the factors related to burnout which causes nurses to leave the profession.

While most US physicians believe that religion and spirituality have "a substantial and generally positive influence on patients' health and that on occasion the influence is due to divine intervention" they do not believe that hard medical outcomes are influenced by this. (Curlin, Sellergren, Lantos, and Chin 2007,651).

METHODS

Research Design

A descriptive correlational design was used in this exploratory study to determine the relationships between the variables of theoretical interest and moral distress experienced among physicians, nurse practitioners, and nurses.

Sample

A convenience sample was recruited among physicians, nurse practitioners, and nurses in two for-profit hospitals and one not-for-profit hospital in two different counties in South Florida as well as a Hospice serving a four county region. Of the 201 participants willing to complete all the components of the questionnaire, 174 were RNs, 10 were nurse practitioners, and 14 were physicians. Several respondents didn't indicate which category they were in but answered all the other questions. Only one physician was female, all ARNPs were female, and 15 (almost 10%) of the nurses were male. The frequency of the other variables can be seen in Table 1.

Table 1
Demographics

		N	Percentage*
Physicians	MD	11	5.5
	DO	3	1.5
Nurses	AD	97	48.3
	BSN	67	33.3
	MS	10	5.
ARNPs		10	5.
	Missing	3	1.5
Gender	Male	26	12.9
	Female	175	87
Ethnicity	White non-Hispanic	158	78.6
	Hispanic/Latino	10	5.
	African-American	9	4.5
	Haitian/Jamaican	6	1.8
	Asian/Pacific Islander	16	8.
	Missing	2	1
Religion	Protestant	83	41.3
	Catholic	71	35.3
	Spiritual (no formal religion)	32	15.9
	Atheist/Agnostic	5	2.5
	Judaism	4	2
	Hindu	1	.5
	Other	4	2
Years of experience	Missing	1	.5
	<5 years	29	14.3
	5-9 years	23	11.4
	10-14 years	33	16.4
	15-19 years	28	13.9
Any formal ethics training?	>20 years	88	43.8
	No	116	57.7
	Yes	81	40.3
	Missing	4	2

*Percentage may not equal 100 due to rounding

Instrument

Measuring moral distress

Corley et.al (2001) originally developed a 38-item questionnaire with a 7 point Likert scale to measure distress reported by nurses. She used hospitals around the country to develop the Moral Distress Scale (MDS). Hamric wanted to include physicians in her study of moral distress and adapted Corley's questionnaire by reducing it to 21 items and constructing both a nurse survey and a parallel physician survey (Hamric and Blackhall 2007). The Cronbach's alpha internal

consistency reliability of Hamric's scale was .83. In this current study, the same nurse questionnaire was used for nurses as well as nurse practitioners and the physician counterpart was used for the physicians. Some questions were the same on both questionnaires and a few were slightly different. Some examples of the questions that were worded slightly differently for both groups can be seen in Table 2.

Corley's original questionnaire had a 1-7 scoring range. A higher score was reflective of increased distress reported by the nurse. Hamric's questionnaire has subjects rate both the frequency and the level of distress the situation causes on a scale from 0 to 4. On the left hand side is the frequency scale which goes from 0 (never occurred) to 4 (very frequently). The right hand scale measures the level of disturbance or how distressing the situation was to the respondent. The scale goes from 0 (not distressing) to 4 (greatly distressing). For the purpose of this study which was looking at the level of moral distress, only the right hand side of the scale was utilized to determine the level of disturbance.

Procedure

Approval was obtained from a University Institutional Review Board (IRB) as well as from the Ethics Committee of one hospital and the research committee of another hospital. Support was granted by hospital and hospice administrations, including approval of the medical and nursing staffs. Many more packets were left at each facility than would be utilized as the distance between them was more than 100 miles. Packets included an introductory letter from the nurse researcher with informed consent information, a demographic questionnaire, the two page questionnaire, and a return envelope. Nurses, nurse practitioners, and physicians voluntarily took the packets to complete. Of the numbers of packets left at all the facilities, there was an overall 45% return rate for the nurse questionnaire, and a 10% return rate for the physician questionnaire.

Data Analysis

Descriptive statistics were used to measure participant characteristics with all the variables as well as the numbers of persons who were distressed by the situations. Chi Square tests of significance were done to assess the relationship between the variables and the questions. For the purpose of this study, those who choose number 3 or 4 on the level of disturbance on the right side of the questionnaire were considered to be distressed by that situation. Variables included; the participants' gender, years of experience, ethnicity, religion, and whether or not they'd ever had any formal ethics training. This was defined as a three credit course on ethics rather than just CME/CEU offerings.

Findings

Table 1 shows the responses to the demographic questionnaire. One final question was included: Have you experienced moral distress in the past? They were then asked to please explain a morally distressing situation on the back of the questionnaire. After each question, the

respondents were asked to rate the level of disturbance or how distressing the situation was to them on a 4 point Likert scale. A score above three was considered to be distressing to that individual. Because the numbers of physicians and nurse practitioners were low, they were grouped together. The analyses presented combine all responses from nurses, nurse practitioners and physicians.

Forty three percent of the respondents had more than 20 years of experience. More than 72% of all the providers had more than 10 years of experience. The average person responding to this questionnaire was a white female Protestant with more than 20 years of experience who previously had never had any formal ethics training.

A score of three or more on a Likert scale of 0 to 4 on the question of whether or not the situation disturbed the respondent yielded some disconcerting results for the nurse practitioners. The physicians were distressed with four out of 21 questions; the nurses with two questions, and the nurse practitioners with 17 of the questions.

See Table 2 for the four questions with six significant findings and the one question with a finding that was close (.08). The significant findings were related to religion, ethnicity, and whether or not the respondent had taken a formal ethics course in the past.

Table 2

Questions on the MDS with significant findings

<p>#8 RN Follow the physician's order not to tell the patient the truth when he/she asks for it. #8 MD Order nurses not to tell the patient the truth when he/she asks for it.</p>	<p>Significant (.05) for ethnicity.</p>
<p>#9 RN Assist a physician who in my opinion is providing incompetent care. #9 MD Assist another physician who in my opinion is providing incompetent care.</p>	<p>p=.08 for having taken a formal ethics course*</p>
<p>#16 RN Follow the physician's request not to discuss death with a dying patient who asks about dying. #16 MD Request that other team members not discuss death with a dying patient who asks about dying.</p>	<p>Significant (.008) for religion. Significant (.05) for having taken a formal ethics course</p>
<p>#17 RN/MD Work with physicians/nurses who are not as competent as the patient care requires.</p>	<p>Significant (.04) for having taken a formal ethics course.</p>
<p>#18 RN/MD Ignore situations of suspected patient abuse by caregivers.</p>	<p>Significant (.018) for religion. Significant (.02) for having taken a formal ethics course.</p>

*While not significant at $p < .05$, the finding was close so it was included.

Three questions were significant at $p < .05$ for the respondent having taken a formal ethics course. Two questions were significant for religion. One found that Atheists/Agnostics and Jewish participants were more distressed than Catholics and Protestants about not discussing death with a dying patient who asked about dying. Another question found that Atheists/Agnostics, those who considered themselves spiritual but had no formal religion and Jewish participants were more distressed than Protestants and Catholics about ignoring situations of suspected patient abuse by caregivers.

One question was significant for ethnicity. Whites, Hispanics, Haitians/Jamaicans were more distressed than African-Americans and Asians about not telling the patient the truth when he/she asks for it.

Table 3 shows the responses to the final question of whether the respondent had left or considered leaving a position in the past because of his/her discomfort with the way patient care was handled at their institution. With all three groups, nurses, nurse practitioners, and physicians,

this finding was significant at $p=.018$. Twenty four percent of nurses and nurse practitioners had left a position in the past and 26% had considered leaving but had not done so.

Table 3

Have you ever considered leaving a position?

	Physicians N	NPs N	RNs N
Yes, I left a position	0	5 (55.6%)	36 (22%)
Yes, I considered quitting but did not leave	1 (.07%)	2 (22.2%)	43 (26.2%)
No, I've never considered quitting or left a position	9 (64%)	2 (22.2%)	85 (51.8%)

Significant at $p=.018$

Finally respondents were asked to share a situation that involved moral distress and continues to bother them today. There were 83 comments. The lengthiest comments were from physicians and nurse practitioners. Five (36%) of the physicians wrote comments; 7 (70%) of nurse practitioners and 71 (41%) of the RNs wrote situations that were disturbing to them. While these comments are still being analyzed; there were some common themes of distress that were noted initially.

- Questionable activities of colleagues
- Patient care being sacrificed due to scarce resources
- Lack of communication
- End-of-life issues
 - Prolonging life at any cost
 - Giving aggressive care that is futile
 - Not honoring advanced directives

Discussion

The graying of healthcare

Nurses under the age of 30 are more likely to leave their job than older nurses (Aiken et al. 2001). Younger nurses do not have the tools to deal with situations involving inter/or intra professional situations, nor the skills to deal with difficult patient situations, nor have developed critical communication skills to deal with physicians and others in the workplace. Several studies found that the nurses' age and years of experience did not make a difference related to moral distress (Corley et.al 2001; Winland-Brown and Dobrin, 2009). One study found that the youngest group which included nurses experienced higher levels of moral distress (Sporrong, Hoglund and Arnetz 2006). One can rationalize that more experienced nurses have the skills to handle morally distressing situations.

Cultural Effects on Moral Distress

Range and Rotherham (2010) found that ethnic background influences moral distress. In their study they note that “European-American and Catholic students reported more moral distress than African-American students” (p.229). This is supported, in part, in this current study where Whites, Hispanics, Haitians/Jamaicans experienced more moral distress than African-Americans and Asians about telling the patient the truth when he/she asks for it. This finding may be explained by a study on cultural differences by Doolen and York (2007). They found that Asian cultures believe individual decision making by a dying patient may isolate him/her from a loving and supporting family and that some African-Americans believe that the family’s voice is more important and would prefer the family or clergy to make a decision at the end-of-life (p.195-196). Another study noted a significant relationship between race and distress with nurse-physician communication. African-American, Asian, and Hispanic nurses noted more satisfaction with nurse-physician communication than European-American nurses (Manojilovich and Antonakos 2008). In a study by Blackhall et.al (1995), Korean Americans were less likely than European Americans to favor telling the truth about diagnosis and prognosis and less likely to choose the patient as primary decision maker.

Religion and Moral Distress

According to Curlin et al., “doctors who are religious are less likely than others to believe physicians must refer patients or disclose information about medical procedures they oppose for moral reasons” (as cited in Cadge, Ecklund and Short 2009, 706). Furthermore, the Association of American Medical Colleges suggests the way physicians relate and deliver care may be a direct effect of their spiritual beliefs (as cited in Curlin et al. 2007). Physicians also convey dissatisfaction “when religion/spiritual knowledge trumps medical recommendations for families’ (Cadge, Ecklund and Short 2009, 715).

With approximately 1.6 million Atheists/Agnostics (Smith-Stoner 2007) and 6.5 million Jews (LeElef, n.d.) in North American, we must understand their perspectives on death and dying. Atheists want to understand the rationale for care and want to be included in the decision making as it pertains to their care (Smith-Stoner 2007). While Jewish people are very spiritual their conviction is that life has infinite value and therefore everything must be done to extend it (Jotkowitz and Zivotofsky 2010). Thus, the physicians’ perspective and the underlying beliefs of the Atheists/Agnostics and Jewish culture may give insight into the participants’ responses in this current study.

The relationship between moral distress and having taken a prior ethics course

In this study, 41.1% of the respondents had formal ethics training in the past. They experienced a significantly increased amount of moral distress than those persons who had not taken ethics training. Does this mean “Ignorance is bliss”? At first thought, one would rationalize that with ethics training, one would be able to handle moral distress; therefore it would not bother the

individual. It is exactly the opposite. With ethics education, one is cognizant of what ‘ought’ to be done and more distressed when it is not. These professionals are more aware of ethically distressing situations and hopefully have the tools and skills to deal with it and that it is realistic to accomplish that so the individual doesn’t get continually frustrated and want to leave the workplace.

Conclusions

Comments from individuals that were handwritten on the back of the questionnaires were disturbing. In general, they were about morally distressing situations that had occurred in the past but continue to disturb the individual on a daily basis. The analyses of these comments will be presented in a future article. Some comments referred to the fact that nursing or medicine is not what the individual thought it was going to be and the stress was not ‘worth it’. The most revealing comment was “I personally know 4 RNs who are no longer working in healthcare due to stressful working situations. I am considering going to retail management—the salary is similar and there are no deaths at Macy’s.” This definitely speaks to the lack of a caring environment and an unethical climate where compassionate care cannot be delivered as taught in school. This should be of great concern to educators as well as hospital administrators. We must address the numbers of healthcare professionals leaving the workplace. The statistics in this study (See Table 3) are overwhelming with 24% of nurses (combined with nurse practitioners) who had left a position and 26% who had considered leaving. These numbers are fairly consistent with Hamric and Blackhall’s (2007) report of 17% of nurses leaving the profession and 28% who considered leaving who had higher levels of moral distress.

Corley (2002) identified research priorities to improve the understanding of moral distress and how to address it effectively, but as of yet, solutions have not been successful. Because addressing moral distress requires making changes, the American Association of Critical Care Nurses (AACN.org) published a free handbook to help critical care nurses make their optimal contribution to patients and their families. The pamphlet is titled “The 4A’s to Rise Above Moral Distress” and uses a model of Ask, Affirm, Assess, and Act to create a healthy environment and an ethical climate. Their model provides a framework and a resource to guide nurses in the understanding of moral distress in the hopes of creating a healthier work environment. The guide defines moral distress, sources creating moral distress, barriers in taking action when faced with moral distress, and identifying what moral distress feels like. When recognizing the signs and symptoms of moral distress nurses are generating an opportunity for change (AACN.org).

Communication between professions has long been known to be a discord in facilitating an ethical climate among physicians and nurses. “Physicians and nurses are too often in conflict and/or separated from joint work for good patient outcomes” (Storch and Kenny 2007,488). In order to support physicians and nurses in accomplishing the moral work that needs to be done, effective communication patterns must be restored to ensure a positive ethical climate.

Healthcare must be seen as moral work so everyone involved from the providers to the patients and families will benefit.

Some strategies for creating a caring ethical climate include:

- Facilitate open interdisciplinary communication
- Support caring for self
- Make sure everyone knows how to utilize the Hospital Ethics Committees
- Foster caring colleagues and a no tolerance policy on lateral violence
- Seek out effective role models for novice nurses
- Provide for an adequate orientation for new staff
- Establish an environment that supports professional autonomy
- Offer ethics seminars which may include Codes of Ethics, ethical principles, and common patient scenarios
- Consider ethics rounds

Moral distress may promote personal and professional growth and enable one to engage in more compassionate care (Corley 2002). Creating an awareness of the moral distress that currently exists in healthcare is essential to assist the professions in creating a caring ethical environment in which professionals are respected, patients' wishes are honored, all individuals are valued, and persons enjoy going to work and don't want to leave. It is a privilege to enter the patient's world and help him/her to receive the best care possible. Caring ethical environments enable professionals to go home at night knowing that they did all that they could while making a difference in someone's life while keeping their moral integrity intact. What else is there in life?

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