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NURSES' EXPERIENCES

OF MORAL DISTRESS

by

Linda Dodson Harrison

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ABSTRACT

The purpose of this paper was to increase awareness about the existence of moral distress. Nurses frequently experience moral distress, yet may not recognize its presence and the toll it takes. Moral distress occurs when a nurse believes she or he knows the right action to take, but is prevented from carrying out that action. Initially distress creates frustration and anger. Over time and with repeated incidences, moral distress creates burnout, job dissatisfactions and results in nurses leaving the profession altogether.

To explore the causes of such distress, six hospital nurses were interviewed about situations that created moral distress for them and each described how their situation affected them. From these interviews two common themes were identified: all nurses were committed personally and professionally to quality and compassionate care for their patients and each identified the sense of powerlessness to act.

Moral distress is a common phenomenon and represents a unique experience for each nurse. Satisfactory resolution of their distress lies in the understanding that nurses must recognize the problem of moral distress, continue to talk about their experiences and consider solutions to ameliorate the distress they feel. Through sharing experiences they can then support and mentor each other and create innovative ways to lessen the sequella of morally distressing events.

Dedicated

To my son Nathan.

You have shown me that

Quitters never win

and

Winners never quit.

Acknowledgments

I wish to thank all the nurses who took time to be interviewed and who shared openly and honestly their stories. Without their participation, this project would not be completed.

I would like to express my sincere gratitude to the members of my thesis committee, Jacob Climo PhD, Judith Andre, PhD and Mary Jo Arndt, EdD. I thank Patricia Jimenez and Kristin Mellon and Ruth Mendel for their editorial help.

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Chapter 1

INTRODUCTION

I have been a nurse for twenty-five years. In that twenty five years there have been clinical situations where I believed I knew the right thing to do, but felt frustrated and angry because I was unable to act. Perhaps a patient needed a medication for pain in the middle of the night and the doctor refused to order anything for pain because I woke him up or a patient with terminal cancer continues to receive treatments that offer no benefit yet leave him vulnerable to infections that cause painful mouth sores, shaking chills and fevers that leave him weak and exhausted and suffering until he dies. For the most part these events created anger, frustration and sometimes guilt for not trying to make the situation "right". I just put the events out of my mind and tried to forget them. As time went on, those feelings of distress did not subside. I began to wonder if I was suffering from burnout. I either needed to explore the cause of my distress and change the way things were or leave nursing. I opted to study this phenomenon further.

I began to share my concerns with my peers, who admitted that they had experienced similar incidences and felt the same frustration. They knew other nurses who left nursing because they could not bear the sense of powerlessness to change the way things were. Almost every nurse I talked with had experienced distressing circumstances accompanied by feelings of powerlessness. I have heard stories from nurses in all areas of practice (obstetrics, oncology, critical care, pediatrics). These are not isolated incidences; these events happen regularly. The six stories reviewed in this paper represent a small sampling of experiences nurses encounter every day. Nurses describe their experiences of seeing patients suffer

needlessly. They describe a sense of powerlessness to challenge physicians or supervisors because they had too many patients or too much administrative paper work to safely care for their patients.

The kind of distress nurses experience is a problem not only to nurses but to the health care system. Corley (1994) writes "ineffective coping with moral distress included crying, sarcastic retorts, withdrawing or going along with the situation, considering resignation" (p. 281). Anger frustration and guilt are not forgotten. The feelings accumulate. These experienced and conscientious nurses are lost emotionally or literally from the health care system.

While nurses are aware of these negative feelings, most are not cognizant of the concept of moral distress. They understand the negative feeling states of anger and frustration, and can identify situations that cause emotional discomfort, but they do not think about moral distress as an entity. They understand the emotion, but not the phenomenon. They may lose satisfaction with their job and leave without ever understanding why, and of course without ever seeking support to rectify the problem.

I would like to suggest that moral distress is part of a continuum of moral thinking. On one end of the continuum there is guilt. Guilt is "a painful feeling of self-reproach resulting from a belief that one has done something wrong or immoral" (Webster's New World Dictionary, 1984). One feels personally and solely responsible for an error in judgement or wrongdoing. At the other end of the continuum is indignation which is "anger or scorn resulting from injustice" (Webster's New World Dictionary, 1984) where one believes another is solely responsible for wrong judgement or wrong doing. I believe "moral distress" falls somewhere between guilt and indignation. With moral distress, one feels a

certain account of moral complicity with the decision because of one's social location. In this study, the nurse is part of the implementation, yet does not agree with the decision. Moral distress represents some guilt for not acting to rectify the situation and at the same time some indignation towards the "other" (physician, supervisor, administrative policy) for creating such a situation.

It is important to increase awareness of the pitfalls of unresolved moral distress, its etiology and essence, and to seek ways to understand why it exists and what can be done to lessen its burdens. There are two definitions that describe the essence of moral distress. Wilkinson (1989, p.16) 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." The Wilkinson definition suggests one feels guilty and assumes responsibility for not acting on a perceived wrong. Jameton (1984 in Wilkinson, 1994, p. 512) believes moral distress occurs when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." Jameton's definition illuminates the morality of not "doing the right thing," but suggests the institutional constraints assumes some of the responsibility for inaction. To those definitions, I would like to add another key factor in moral distress. It is the incongruence between the high standards nurses believe they must uphold (See Appendix A, Code for Nurses 1985) and the complexity of patient care in the current health care environment. They have the responsibility for their patients, but do not have the real power to be the advocate they believe they should be. The physician and the hospital administration often take precedence.

Chapter 2 is the literature review. The review of the literature describes the history

of articles written on moral distress, offering definitions and case studies that described the existence of this phenomenon. It offers a description of the perceived barriers: powerlessness, conflicting loyalties, close relationship and the strong commitment nurses have with their patients. Finally it presents suggestions from the literature on ways that nurses can address their distress.

Chapter 3 describes the narrative methodology using taped interviews to describe morally distressing incidents and the participants' emotional responses to those particular situations. Those in depth interviews represent a richer description of the emotional toll nurses experience in their clinical practice than has been described in the literature.

Chapter 4, Narratives, includes a synopsis and interpretation of the six interviews and reflects a diversity of situations, the resulting frustration and negative emotions that nurses experience. This chapter is followed by Chapter 5, Discussion, which offers an in-depth review of the narratives and recognition of common themes. Once these common themes are recognized, it is possible offer viable solutions. I offer conclusions and recommendations in Chapter 6, Conclusions and Recommendations. Chapter 6 also suggests further research on moral distress.

I hope the ideas put forth in this paper capture the factors that contribute to moral distress, advance dialog among nurses about this topic, and provide insight into ways that resolve or abate such distress. Nurses remain an integral part of patient care, but must seek ways to maintain job satisfaction and remain emotionally healthy.

Chapter 2

LITERATURE REVIEW

It is probably safe to say that moral distress has always been a part of nursing. It has not been widely recognized or discussed as such. A search of the medical and nursing literature since 1966 finds the earliest writings using the term "moral distress" were written by Jameton in 1984. Wilkinson (1994) cites authors Hofling, (1966) and Jacobson, (1973) as describing stresses of nursing, but I did not find the term "moral distress" used before 1984. In the 1990's more authors Benoliel (1993), Corley and Raines (1993), Cunningham, (1993), Daniel, (1998), Doka, (1994), Fowler (1993), Perkin, Young, Frier, Allen and Orr (1997), and Taylor, (1993), wrote about moral distress and its effect on nurses.

Corley and Raines (1993) reported that 55 percent of nurses, regarding decision making, reported conflict between personal values and professional values. Moral distress is the result of tension between what nurses are taught in nurses training about their obligations to the profession of nursing and the realities of real clinical situations. "Although nurses are socialized to perceive themselves as professionals with autonomy, full accountability and decision making abilities, their actual work situation is a different picture" (Corley & Raines, p. 614).

Corley, (1993) Raines, (1993), and Scanlon and Glover, (1995), believe the American Nurses' Association, Code for Nurses (1985) is the basis for the conscience of nursing. The code addresses two facets of nursing: first the conduct of nurses in their care of clients which includes the ethical principles of autonomy, beneficence, non maleficence, veracity, confidentiality, fidelity and justice. Second, it addresses maintaining the quality and competence of nurses. "Professional nursing is regulated by standards that specify the

conduct of practitioners and hold them accountable for failure to uphold these standards" (Raines, 1993, p. 614). However, the standards are lofty and "the applications of these principles as absolutes is impossible. The practice of nursing involves people, human relationships, and individual virtues, not abstractions" (Raines, p., 539).

A key issue of moral distress identified in the literature is the sense of powerlessness nurses feel (Erlen & Frost 1991). As a result of feelings of powerlessness nurses experienced negative consequences such as anger, frustration, job dissatisfaction and even leaving nursing altogether. Nurses may believe an action is morally wrong, yet feel powerless to act. The perception of powerlessness originates from a variety of causes. Some acute care inpatient situations create the sense of powerlessness that overwhelm nurses and influence their ability to give care (Cunningham, 1993; Doka, Rushton & Thorstenson, 1994; Daniel, 1998).

Another common reason often cited is the physician/nurse relationship. Dalby related a study by Haddad (1988) that found 75 percent of the nurses they studied had to compromise ethical values, primarily due to physician requests. Benjamin and Curtis (1992) wrote that physicians are at the center of decision making and the nurse acts as a "passive recipient." Medical care is under the direction of physicians; nurses follow the physician orders and so traditionally physicians have more "power" over the management of patient care.

Another issue that might be considered could be the traditional power imbalance between men and women. Brody, (1992) suggests that the "relationship between men and women is basically a disparity in power, with men having the social status and control necessary to maintain their privileged power status"(p. 28). Medicine has traditionally been a male dominated field. Historically most physicians have been men and most nurses women.

At the same time, men continue to maintain most management positions in healthcare domains (Sherwin, 1996a). Sargent and Brettell (1996, p. 189) write, "(w)omen as a group still have relatively less public power than men do collectively...policies and practices of those institutions frequently favor men's interests over women's."

The sense of powerlessness also may emanate from the institution that employs nurses. Ray (1994) stated, "perception of powerlessness in the organizational work environment was negatively related to ethical practice" (p.105). For fear of reprimand or dismissal by the institution, nurses may believe they must follow physician orders, or care for more patients than they feel is safe. Corley and Raines (1993, p. 612) related that, "(n)urses often perceive themselves primarily responsible to the employing institutions and the physician. ...The influence of the organization can be more powerful than the nurse's commitment to either the professional standard of practice or to the patient."

The close connection to patients makes nurses more vulnerable to moral distress. Gadow (1980), LeVille Gaul (1995), Scanlon and Glover, (1995), Taylor, (1993), and Wilkinson, (1994) identify the "hand on care" of nurses as an important factor in attachment and connection to patients. Nurses care for patients by physical touch, visual observations and hearing verbal and non verbal(e.g., breath or bowel sounds, equipment beeps and alarms). They touch, see, and hear the patient and then assimilate the information in order to understand the whole patient. Doka, Rushton and Thorstenson (1994) write about care giver distress. Anguish is "experienced as a threat to our composure, to our integrity, to the fulfillment of our intentions, and to who we are as nurses and as individuals. ...(S)uffering is related to our competing obligations to the patient, the family, our colleagues, the institution, and society in general" (p. 348).

Nurses need to understand the standards set forth by their profession (Raines, 1993; Scanlon & Glover, 1995) because the standards provide a foundation to direct and guide nursing practice. They must then, however, learn to balance competing obligations such as to patients, physicians, the institution and their personal beliefs.

Jameton (1990), Le Ville Gaul, (1995), Doka, Rushton, Thorstenson, (1994), and Raines, (1993), invite nurses to examine their values, both personal and professional, to talk about issues that create stress and to set priorities that will empower nurses to balance personal, professional and institutional values for the benefit of care givers and those who receive care.

Chapter 3

METHODOLOGY

To gain a deeper understanding about moral distress, from the viewpoint of individual nurses, I selected a narrative analysis. Mishler (1986) writes that, "(t)elling stories is one of the significant ways individuals construct and express meaning"(p. 67), and that "narratives are one of the natural cognitive and linguistic forms through which individuals attempt to order, organize and express meaning" (p.106).

Narrative analysis requires close attention to what interviewers and respondents say with less emphasis on syntax and semantics that one would find using statistical analysis of coded data. The intent of this study was not to analyze the semantics of moral distress, but rather the essence of moral distress. For example, what situations cause distress and whether there were common themes among the stories. Some narrative involved patient care, some

short staffing, and others administrative duties. The diversity of situations described in the six narratives made it difficult to use analytical comparisons.

The interviewing technique was unstructured, which Mishler (1984) identified as most appropriate for preliminary research. This was my first attempt at narrative research and no other research using moral distress as a topic was recorded in the literature. Participants were told the purpose of the research and asked six open ended questions. The interviewer allowed all questions to be answered with minimal interviewer input. A more structured interview with extensive questions would have guided the responses too much. I was more interested in responses that were not prompted and directed by the interviewer. A more structured interview with specific questions about particular circumstances would have affected the spontaneity and purity of responses. Prompting would have the potential of revealing what the interviewer wanted to hear rather than more candid responses.

The analysis did not distance itself from the purity of the respondents by using statistical analysis of the syntax and semantics as might be required in more epistemological, temporal and objective content analysis. It sought to understand what nurses perceive as morally distressing and how it affects them personally and professionally. The subjective very personal expression that narratives reveal get at the heart of the matter in all the uniqueness of each nurse's experience and perceptions of the situation. At the same time, the narrative suggests that larger issues like moral distress are widespread.

Hearing and telling stories about moral issues is not new. Bioethical, medical and nursing journals offer a number of case studies that reflect moral distress (Perkin, et al, 1997; Corley, 1995; Wilkinson, 1988). The studies explore the situations within the medical ethical framework of moral principles such as autonomy, beneficence, non maleficence, and justice.

The studies also explore the frustration and anger nurses feel when they are not able to provide the care they believe the patients deserve. I believe there is more to understand about these stories. Patient care management is a complex interplay of medical care (physical healing), psychosocial (emotional and social influences), and political/legal factors (reimbursement, health care regulations). This complexity may interfere with care that is in the patient's best interest and contribute to the distress nurses experience. Case studies from the literature gave only limited details about morally distressing situations and none described medical-surgical nursing perspectives. I believed in-depth interviews would reveal more insight into the social sources and outcomes of moral distress.

Recruitment took place in a variety of ways. Once I was ready to recruit participants, I asked nurses I knew to suggest others that might be willing to participate. The unit manager on a medical surgical unit referred three participants, the other three volunteered after I told them about the study and I asked if they would participate. None were supervised by or worked directly with me. All participants in this study volunteered their time. All agreed to participate because they believed their stories were important, and believed moral distress was an important topic to explore.

I had originally planned four interviews, but five nurses volunteered. A sixth interview was added to get a second male interview. The first male seemed so distressed and angry about his experience, I thought another male should be interviewed just to see if other male nurses seemed to express such anger. The second male did express anger, but the intensity was similar to the female interview participants.

I told each one I would ask him/her to relate a distressing situation ; a situation where they felt they knew the right thing to do, but were not able to carry out that action. All

were assured that their narrative and names would be kept confidential. After asking them if they would be willing to participate, I then set up an appointment with them. We would then meet at a place convenient for each one. I requested that it be a place that offered privacy and no interruptions. Two interviews were conducted in the hospital, two in the participant's home, one in the interviewer's home and one in an empty classroom on the Michigan State University Campus. No other persons were present during the interviews.

Each participant signed a consent form (See Appendix B) and was asked the following questions: (1) Can you tell me about a patient care related situation that upset, frustrated or irritated you? Describe a situation where you knew the right thing to do but felt that politically or socially you were not able to act. (2) How did you resolve the distress or frustration? (3)What meaning did the situation have for you? (4) Do you feel these experiences "spill over" into your personal life? If so how? (5) What barriers do you see that prevent you from carrying out your responsibilities as a nurse? (6) What person, institutional policy or other factor conflicted with your responsibility to the patient? Questions were not necessarily asked in the same order, but each participant was asked the same questions. The responses were in no way prompted. The interviews were taped and transcribed verbatim which allowed careful review of content and lessened the possibility of inaccurate recall.

The interviews lasted fifteen to twenty two minutes. All participants seemed relaxed and cooperative. No limitations were placed on respondents regarding the type of event. They were allowed to describe any situation. It did not matter when the event occurred (one participant related a story that happened twenty years earlier) or who was involved. Some stories were patient care related, others concerned administrative duties that kept them from accomplishing patient care.

Each interview was transcribed verbatim to allow a complete and thorough review. I explained that the purpose of the study was to get a deeper understanding about situations that distress them, to increase awareness about the existence of moral distress and to gain insight into ways that might help nurses cope with the emotional fallout of such distress.

Characteristics of Nurses Interviewed Table 1

Participant	Age	Years Experience	Gender	Degree in Nursing
#1	47	26	FEMALE	Masters
#2	54	31	FEMALE	Bachelors
#3	45	20	FEMALE	Bachelors
#4	51	1½	MALE	Associates
#5	49	18	MALE	Associates
#6	44	2	FEMALE	Associates

All the nurses were between forty-four and fifty-four years of age. A nurse who is over forty would have more life experiences to draw from than would a twenty-year old nurse fresh out of nursing school. Their experience as a nurse ranged from eighteen months to thirty one years. Three of the nurses held Associate's Degrees in Nursing (a two-year Community College preparation with both classroom and clinical experiences), two had Bachelor's Degrees in Nursing(a four-year college degree program with three years of clinical experience and classroom preparation combined with an emphasis on nursing theories), and one had a Master's Degree in Nursing (a Baccalaureate degree in nursing and at least two years of advanced nursing education for a Master's degree). All participants were Caucasian and employed full time in an acute care hospital in a mid western city, population over

600,000. (See Table 1).

Only one nurse was familiar with the term "moral distress," so I shared one or two examples from the literature or my own personal experience. For example, Ustal (1990) wrote about Jason who was seventy-one and adamant about not being put on the ventilator, yet his wife wanted everything done and the physician refused to write a Do Not Resuscitate order or another situation where half the family wanted everything done and the other half wanted treatment stopped. From my own personal experience I shared a story about a patient who was forty-three with a terminal melanoma, which has no known effective treatment. He was offered and given very toxic chemotherapy under the premise that it would prolong his life. He died a week later after suffering from the severe side effects of his chemotherapy.

They were asked to identify a situation that had occurred where they felt they knew the right thing to do, but felt they could not act. All six nurses shared their powerful and compelling stories. I did not judge whether the situation described was actually a moral issue or not. It would be inappropriate to pre-judge a particular narrative's content as to its moral relevance, only the teller needed to decide. Each participant spoke about an issue they believed was morally wrong and caused them distress.

Once the idea was explained, all participants were able to relate an incident. My emphasis was not to focus on the actual incident, but the effect it had on the nurses and perhaps discern why it distressed him/her. The incidents and interpretations are discussed in detail in Chapter 5, Discussion of Narratives. It was noteworthy that the term "moral distress" was not a term they recognized, but all knew the experience. They all were grateful for the opportunity to share these troublesome stories and hoped that nurses would benefit from the information they shared.

The interview process was an enlightening experience. Nurses talked openly about a subject they seldom talked about, they all had different experiences, and they shared situations I had not thought of as morally distressing until hearing their stories. I hope the analysis contributes to a better understanding about the painful issues nurses face every day. My intent is to explore the common themes in each story, consider why they might be there and thus gain insight into possible resolution of the distress.

The interviews were compelling. The frustration, anger, disillusionment was genuine as was also the overt sense of duty and commitment to the profession. Those in depth interviews represent a rich description of the emotional toll nurses experience in their clinical practice. Unfortunately, time limits precluded me from doing more interviews, but it was evident many more stories could be told.

Using the methodology of narrative analysis lends its self to this topic. The descriptions, the essence of moral distress, are a result of open ended inquiry into what causes them moral distress. I reviewed the narrative as objectively as possible, and tried to see the world through the eyes of the subject. I allowed them to describe any situation they chose. The first and sixth example were about clinical situations where patients were in severe pain and were terminal yet the doctor would not respond to the nurses pleas to help the patient be more comfortable and allowed to die without suffering. Narratives three, four, and five described examples of nurses who were overwhelmed by the demands of their job. Those demands kept them from delivering quality care they believed they should.

This study's value rested in the exploration of the important, difficult and interesting aspects of moral distress and its possible origins and the influence such distress has on nursing practice. The value lies in its capacity to identify and articulate the themes of moral distress

that are common to the nurses in this study.

Chapter 4

DISCUSSION OF NARRATIVES

The following are descriptive summaries of the six interviews.

Situation 1

A forty-seven-year-old female nurse with twenty-five years of experience related a story that happened twenty-five years before. Briana was caring for a young male patient with burns over 90% of his body. Three areas of concern for burn patients include: loss of skin integrity, electrolyte imbalance including great problems with swelling and pain from exposed nerves and contractures. The skin is the body's best defense against infection. Once the integrity is lost, the risk of infection is great. Also once the skin is lost, body fluids escape the vascular system creating a tremendous problem with edema (swelling) and fluid imbalance. When the skin is burned, the fascia, which are fibrous membranes that unite the skin with underlying tissue, contract and become rigid. This impedes circulation and in areas such as the chest, prevents expansion and leads to suffocation if the stricture is not relieved. Fasciotomies (longitudinal cuts) relieve the stricture but also expose nerve endings which increases pain. It is not possible to completely anesthetize a patient from the severe pain of burns, to do so would kill him.

This particular patient had no chance of survival and although severely burned was alert and coherent. The physician decided to treat this patient. This patient required one or two nurses twenty four hours a day to care for him. Each day meant hours of painful debriding (*cutting away dead tissue*) inch by inch and fasciotomies *(cutting the fascia to*

relieve contracting scar tissue). Third degree burns means the nerve endings of the skin are destroyed, and therefore do not cause pain, but any areas with first and second degree burns are very painful. The patient was given pain medication that helped relieve some discomfort, but certainly not all.

When asked, "Did it add to his suffering?" She replied, "Yes, because the longer he was alive and the more fasciotomies you have to do because the eschar (*dead tissue*) gets so tight. You know it would have suffocated him. ...Then you opened nerve endings to be available for pain so I think he was more uncomfortable."

Later, I asked, "Was that part of your frustration?" Briana expresses empathy for the physician in that "dealing with the physician, who I think at the time was probably unable to deal with it himself. ...It was probably very difficult to think about it, for the physician, to know when to say stop. ...I think it was difficult for him to say stop when we all knew somebody needed to say stop and it was basically his call. ...The doctor was just not comfortable with 'do not resuscitate' and I believed that the situation could have been remedied fairly quickly without a lot of suffering on his (the doctor's) part." It was very painful "watching someone suffer when there was no gain in it. ...We (*the nurses*) all knew somebody needed to say 'stop' and it was basically his call. ...We had approached the physician to allow this patient to die, but "I just think he was not in a position personally to say stop."

The nurse believed she knew what was best for the patient and that was to allow him to die comfortably and with dignity. She did talk with the physician about allowing the patient to die, however he was unable to let that happen. Although he did not withdraw life support as she believed he should, she expressed empathy for the discomfort the physician had

watching the patient suffer and yet having difficulty stopping life support. Briana expressed distress about the patient's continued suffering and felt powerless to change the circumstance because the physician was in charge.

When asked what meaning this had for her, she admitted the event created some sadness, but did not adversely affect her personal life. She was able to detach the events in her professional life from the events in her personal life.

When asked, "Do you think you would handle it differently today?" Briana replied "Yeah,...I would be more comfortable talking with a patient. ...I think the whole attitude in health care is now different so that people are a lot more comfortable saying this is as far as we can go. ...My place as a nurse is to support them in whatever decision they (*the patients*) make. So if they make a decision to go the long, hard way...I, as a professional have to support that." She believes it may be difficult to watch a patient suffer, but she would support the patient's decision.

"Nursing as a profession has grown and changed and there is much more ability to have a collegial kind of relationship rather than physician-handmaiden. ...I think it still happens to some extent, but certainly happens to a lesser extent now. ...I think they know that patients have the right to make decisions."

The difference she perceives twenty years later is that the patient has more to say in the decision making process about continuing treatment or not. She would share her thoughts with the physician, if she disagreed with his management, but would support the patient if he/she chose to continue treatment. The patient's input would make the difference to Briana whether the treatment continues or not.

Situation two

A fifty-four-year-old nurse with 31 years of experience related a story that happened about two years ago. Mary was the IV (*intravenous therapy*) nurse who administered chemotherapy for Mr. B. when he was admitted for treatment related to his lymphoma. He had received several drugs, but one in particular, Vincristine, has the risk of bowel obstruction secondary to its neurotoxic effect on the bowels. This patient had completed his chemotherapy and was ready for discharge. As often happens after chemotherapy, his white blood cells that provide immunity were quite low, but not low enough to warrant keeping him the hospital.

Mary became concerned about the patient's bowel status. He had not had a bowel movement in several days, but was not uncomfortable. There were no signs of impending bowel obstruction. He had complained of some nausea, but this was common with chemotherapy administration. The patient wanted to go home. Since there were no obvious reasons to keep the patient in the hospital, the physician planned to discharge him.

Mary stated she "intuitively" believed the patient would have serious bowel problems after his discharge. He had not had a bowel movement and his nausea concerned her. She tried to convince the Physician Assistant to keep him in the hospital until he had a bowel movement, but there was no justification for keeping this patient in the hospital. Consequently he was sent home only to return two days later with a perforated bowel which required surgery. His post operative course was complicated by his low white blood count and resultant infections.

She stated, "I felt we did a poor job caring for this patient, I feel like every nursing judgement we had, just in this area as an IV nurse was, we fell short, way short. ...(I)t was

not really my job,...I was sick (*pause in dialog*)...I was devastated. It was like all I could think of was this poor man came into our care expecting that we would act responsibly and that we would do the things that were necessary for his outcome and we fell short of that."

She felt the Physician's Assistant or the other nurses should have intervened to insure the patient had a bowel movement before discharge. Mary desperately tried to have the patient's discharge canceled. However, to have held up a discharge for lack of a bowel movement in an otherwise stable patient would be unusual.

For whatever reason, Mary definitely felt responsible for what happened to the patient. This narrative reflects this nurse's strong sense of responsibility to the patient, but also may lead us to ask, how far should that responsibility extend? Harm can result and a nurse is responsible for that when nurses fall short in patient care, but in this instance there was no immediate danger to the patient. All might have gone well, but the potential was there for problems and in this case the patient developed complications. As a result of the patient's outcome the nurse arranged an inservice to teach her peers about the potential side effects of Vincristine. This seemed to be a positive response to an unfortunate event and served to ameliorate some of her guilt.

"...(W)ith the advent of shorter hospital days with my change in roles, there has to be a more creative way of accomplishing patients' needs. ...There has to be an assertiveness on the part of the nurses who intuitively know something isn't right...and if necessary go the step further and go to the charge nurse or even the department manager." Mary appeared distraught as she described these events. Her voice sounded emotional and shaky while describing these events.

When asked how this situation affected her, she related that, "now I don't care

anymore. I don't think the quality of care is adequate to be able to pick up things like that. If my family is in the hospital, you best believe I will be there probably 24 hours a day. I just think people are not cared for in a way that when they leave you know for sure their care was adequate. ...I think the pressure to transfer out of the hospital somewhere else is present, for whatever reason either the hospital or the insurance companies pressure. I think it has interfered with good judgement."

Unfortunately, this incident created a serious mistrust of the patient care system where Mary worked. Her distrust of the competency of the nursing care spilled over into a concern for her own family members. She believed it was not safe to leave them alone in the hospital. Her distress over this particular situation truly colored her perceptions about patient safety.

Patients such as Mr. B are at risk for a variety of complications, but it is not reasonable to keep them in the hospital without medical evidence of such a problem, such as a bowel obstruction. That would be an unnecessary use of hospital resources and a continued isolation of the patient from his home life.

The interview continued, "In terms of the way that your handle situations like this, can you see a change from 25 years ago to now?" Mary replied, "I'm a lot more mature in the way I deal with it. ...I incorporate other people. I think there is a great deal of stress." It seems as if she feels some support by involving others in patient care situations, yet in this particular incident, she took considerable responsibility for an outcome (*a perforated bowel*), no one could have predicted. This incident reflects the enormous responsibility nurses feel for their patient's welfare, even in instance where they have no control over the outcome.

Situation three

This story was related by a forty-five-year-old female nurse with twenty years experience. Ellen was working in an intensive care unit caring for two very critical and unstable patients. One patient was an old man on a ventilator who was "frightened and scared," the other was an elderly woman with severe liver disease who was "obtunded and stuporous." (*Obtunded means no sensitivity to pain or verbal stimulus, comatose.*) The unit was short staffed, meaning there were too few nurses to adequately care for the patients.

Ellen, relates, "I'm running from room to room. When I approach the bedside of the man, he keeps grabbing my hand and he has just this awful look of terror on his face, he is so frightened and so scared. And of course he can't talk because he has a tube in his throat. And, I keep trying to reassure him, but I keep feeling like I'm rushing. ...What I ought to be able to do I can't do because I have this other patient and I shouldn't have this other patient." Ellen is concerned about the other patient as well, "I'm giving this lady enemas, she's laying in poop, ya know. ...What about this woman's dignity?" Her concerns are not just for the physical needs of her patients, but their needs for compassion and respect for them as a human being.

Ellen then receives a call from the supervisor who wants to send another patient. She tells the supervisor she cannot possibly take another patient. The supervisor relates they must take this patient because they have the only critical care bed open. "While I'm talking to her on the phone the alarms are going off in the two rooms of my patients. ...We're supposed to have eight nurses and we have five...and I'm telling her to send the patient to somewhere else, ya know, to another hospital, I don't care where. But, I'm going to hurt somebody, ya know, somebody is going to get hurt up here, ya know." "Having the one patient is more than

enough work for one nurse to do. In addition, I am in charge . . . and all the other nurses are in as bad a shape as I am." And this is the typical kind of story. We end up having to take this other patient, now I have three patients who are getting 'shitty' nursing care." Ellen with a tense voice expresses her frustration and anger. "It is immoral to care for patients like that."

She believes she cannot refuse to take the patient. Not only will she be "wrote up" Monday morning for refusing the patient, but also for not providing adequate care for the three patients she is assigned. "I fear getting fired because I didn't take the patient. I felt like my recourse was to go home, abandon the patients and that is not a real recourse." She admits that abandonment of the patients was neither morally or professionally an option, but those comments reflect the intensity of her frustration and sense of powerlessness over the situation in that moment. Legally nurses cannot abandon their patients, but she must consider documenting the incidence and presenting her concerns to her manager, the nursing executive and the CEO of the institution if necessary.

At the time the supervisor calls, Ellen did not have the time to "stand there and argue about it. ...I might have been able to argue...but while I'm on the phone trying to argue... the patients...need my attention right now. She agrees to take the patient because she did not have the time or energy to plead her case further. The supervisor, Ellen's superior, needed a bed for a patient and pressured Ellen to comply even as she protested. Ellen felt powerless, at that moment, to refuse the patient. Ellen struggled for several reasons: 1) there was insubordination if she refused the patient, including a reprimand from her manager and "black mark" on her personnel record, 2) she was jeopardizing the care of those patients already under her care, 3) she was also increasing her professional liability by caring for more patients than was safe and if an injury resulted, it would be her own professional license at risk.

These thoughts go through her mind within moments. The frustration and anger must be subjugated quickly so she can focus on the critical care needs of her patients.

When asked if there were things she could have done, she states, "you could demand the administrator on call be called... You could tell your department manager on Monday. ...But this is a common occurrence that is happening to nurses over and over again. And then it's like, they've heard that before." Ellen realizes there are ways to express her concerns, but believes those options will not provide relief for her situation.

Ellen goes on, "yes, I mean, I didn't kill anybody, but it's like a wonder that either I didn't make a mistake...not to mention the emotional needs of this old man, and then, you go home and I am tossing and turning, I can't sleep, I'm angry. I'm angry about the whole situation. Frustrated, I don't want to go back to work. ...accepting the care of the patient you don't have staff to provide for is immoral, that is wrong." She struggles with these care issues in her private life. Ellen suffers from insomnia now and stated, she had done "unhealthy things to cope and it is what I think a lot of nurses do." Unfortunately the emotion does not dissipate. Insomnia and job dissatisfaction are the result of the inability to channel her emotions in a healthy way.

Ellen has concerns for the other nurses she works with as well. "I see more and more young nurses really detaching themselves and trying to become more technical and making that their focus, because if you for one minute have to think of these people as human beings, then you can't do it without it crushing you emotionally. ...They pretend they (*the patients*)are not people, they are not human, they are a blob of protoplasm lying there and they (*the nurses)*are like a glorified auto-mechanic, ya know. And that's how they cope, unfortunately."

When faced with administrative obstacles she pursued further education in hopes of using that education to make a difference. Now she has begun to invest more energy into pursuing a Master's degree. "I'm trying to help them. ...I went back to graduate school...to read, study and learn...to understand the experience of illness, to 'one on one' help people, other nurses . ... Well you know you are not going to change the world, but you are hoping.... this will give me ...more opportunities." It seems she has found one healthier way to make a difference. Although there were times she considered leaving nursing, she chose the path of investing time, energy and focus to make a difference for her patients, herself, and her nursing colleagues.

Situation four

Situation four is told by a fifty-one-year-old male with one and a half years experience. Although David did not describe a particular situation, the distress and frustration he described were noteworthy. The circumstances involved being overwhelmed by all the responsibilities surrounding "paper work." So for the purposes of this discussion, excessive "paper work" will represent the situation of moral distress.

David seemed burdened by the tremendous responsibility nurses have in caring for patients. He states "what we are doing really can affect people's health and well-being and it is not to be taken lightly. People tell me that I need to lighten up about it . . . , but I am always reminded of the indoctrination that I've had in nursing school and from many sources . . . If you make the wrong decision, it's not the person giving you the advice who is going to be responsible, it's you. So everything falls back on that individual nurse . . . " The responsibility of paperwork in addition to patient care is overwhelming him. "This is all very

personal to me, but it is still just a general systemic situation that I am reacting to, I think. I am starting to question my own suitability for the given floor I'm on. It feels as though everybody has been in my position and they have come to some kind of terms with it. They have either gotten out or they have gotten beyond it through just sheer perseverance or what ever it might be. They are sympathetic in a way, but they have concluded there really is no need to solve this problem and if I stick with it I will get over it. This is the attitude I'm hearing."

"I feel in general nursing expects more of individuals than is reasonable. I found that to be true as an employee of a nursing home, before I worked here, that the amount of work expected and the time allotted for a new nurse just seems insurmountable. The kind of advice that you get, even from people who are supportive is 'just do it', 'do the best you can'. At that point, my own insecurities move me into an emotional state that is very hard to get out of and for me manifests as anger."

"Most of the time I am working in an angry frame of mind. As far as I can tell, other people don't react that way. ...I tend to think a lot of it's (the)culture of nursing, that nurses feel 'called' to the profession, many of them do and I don't feel a 'calling' in that way. So for me it isn't a matter of 'let's make this sacrifice of trying to do more than you are prepared to do'...or 'I have always wanted to be a nurse'. ...I have heard this type of explanation from people; 'that is what nursing is, you have to expect it', and 'if you are called to do it, you just do it and you get through it'. And the first year goes by and then the second year goes by and things get a little easier. ...Certain skills are becoming a little more...I'm becoming a little more adept at them. But the emotional state hasn't changed."

David struggles with both his lack of experience and his mind set about what a nurse

ought to be. He does not feel a "calling". He feels like an outsider in a culture that expects nurses to perform under unrealistic expectations and yet do not challenge the system. He struggles with inexperience and the burdensome responsibility that a license to practice nursing carries with it. His coworkers disconfirm his struggles as a novice nurse who is overwhelmed by the work load and the gravity of responsibility nurses carry. Mentoring by his co-workers would help him as a nurse and as a person who needs support and comfort.

David believes the ancillary staffing levels have been decreased at night which adds to his work load. When he complains, the complaints fall on "deaf ears". "They've heard it all before." He has not tried to confront management as "it has been done many times before."

When asked whether his anger and frustration transfer into his personal life David answers affirmatively. "My work situation really affects my outlook on everything and this past year, I think I have become rather reclusive and that has a lot to do with working the night shift. But more than that, I think it has affected my optimism. I used to consider myself a pretty optimistic person, but having this continual sort of low grade anger when I think about work, even when I'm not at work, that has affected the rest of my personal life. He believes the feeling as "low grade anger" and the loss of optimism are a direct consequence of his overwhelming responsibility at work. He believes the bothersome smoldering anger will at some point cause him to leave his present job.

Situation five

A forty-nine-year-old male with eighteen years of experience tells of his distressing situation. Currently Michael is a charge nurse on midnights on a 40+ bed medical unit. It

seems his main concern is staffing problems and its subsequent effect on patient care. His struggle surrounds the number of nurses who leave because they are "too stressed". "New staff are being inundated with so much that I'm really afraid that we are going to start losing some of them again before we even get them seasoned." He states that eight nurses out of sixteen have recently left to find work in other areas of the hospital. With the influx of so many admissions and the number of discussions that he has with the Department Manager he wonders why nothing changes. Care of patients is "what we're all about". After eight admissions in one night, Michael describes the frustrations nurses feel. "Dealing with the frustrations of the individual, getting the tears, the 'I'm going to quit' syndrome... all that plays a part when people don't feel adequate in the situation." I asked about the feelings of inadequacy and he goes on, "yes, inadequacy, intimidation, to the point where I can't do this kind of thing. ...And even a person who has been here a long, long, long time who was just in tears with me the other night , stated, 'it's time to get out'."

When asked how these situations affect him, Michael relates that it makes him angry and he struggles with outbursts of that anger. "So I get angry, then I'm afraid I will have my little outbursts which aren't appropriate." He realizes he is the charge nurse and ought to maintain his control. He does feel pressure to maintain emotional control to demonstrate a positive role model believing he is also responsible for the welfare and contentment of his staff. "I know what my job entails and I know what we are expected to do here. I know what we are all about, but there's a part of me that says, 'slow down, this boat is going a little too fast for us and we need to be careful'." He then struggles to regain emotional control so he can focus on his job, which includes patient care and management of his nursing unit. "I think concern for the individual nurse who's trying to do a good job and really feels

frustrated. But the flip side of that, (as an aside he goes on) and I will kind of tell on myself–that is I'm in a crummy mood because of all of that, that does filter over and does impact on them. So, in that respect, not a real good example...because sooner or later they are going to start feeling the same way you do."

"I try to encourage them, even when I'm not encouraged. I just think I am trying to affect change that I can't affect, that I really know that I'm powerless to really do anything about it. "You can't give patients the kind of care you want to . . . you are just trying to get the tasks done. ...At midnight you might be able to handle five-six-seven patients, but if they are all a lot of care, a lot of work that really weighs on. ...You can't give that patient the kind of care you want to, you can't divide that much time between all those people who need, because you are just trying to get the task done, let alone...talk with somebody, pat somebody's hand, tell them that you care about them. ...Certainly the climate has changed a lot. People are sicker...we are full all the time. We don't have breaks (*i.e. times of fewer patients*) like we used to have. ...So the only way they can get anywhere with that is that if they 'call in' (*call to say they are sick and cannot come to work*) to get a day of reprieve. Michael believes "the staff gets so stressed they become physically ill or stay home with 'mental health days' because they are emotionally exhausted. That leaves everybody short. ...But, I can't operate that way and there are a lot who can't."

However, being a patient advocate also carries with it the risk of a reprimand, which he is willing to take if it serves the patient's best interest. He cites an example of a patient admitted with severe gall bladder pain who insists on having her new born baby stay with her. He tried refusing the patient for the safety of the newborn. The baby would be at a definite risk of acquiring an infection in a patient care area where people are ill with pneumonia and

other types of communicable diseases. Michael admitted he would ultimately take the patient even though it was against his judgement.

He admits he has been "written up" with a reprimand that went into his personnel file. He understands this may influence his opportunities for promotion or transfer. Even at that he questions how much more he can take. He entertains leaving his present position, but believes he is limited by his Associates Degree in Nursing. Most management positions require a Bachelor's or Master's Degree in Nursing.

Michael ends by saying, "I'm trying to affect change that I can't affect, ... I really know that I'm powerless to really do anything about it. I don't know that anyone could do anything about them." He believes he is caught in the middle between management and the nurses he works with.

Situation six

Celine, a forty-five-year-old female nurse with two years experience relates a story about a situation in which an elderly female patient was transferred to her care. "They knew she was going to die, it was just a matter of time. ...She came over with no pain meds whatsoever at all, nothing. And, she was okay for a while, but then it was obvious that she got in pain. I mean, she went from verbalizing to not being able to talk, to moaning, to groaning, facial grimacing. I mean, every thing we know that when a patient can't actually say 'I'm in pain'. You can tell they are in pain." The family had agreed not to resuscitate her. The plan was to "keep the patient comfortable" and allow her to die peacefully.

When Celine called Dr. Diamond to request pain medication, he refused to order

anything. "He was a jerk about it and he refused and hung up on me." When Celine told the family there was nothing for pain, "they were very, very upset. So I called back and he *(Dr. Diamond*) wouldn't even talk with me. ..It was so frustrating, the family wanted me to make her comfortable and they said that is what Dr. Diamond agreed to when he transferred this lady to our unit. ...I must have called back three or four times. ...(*emphatically she stated*) and the answer was No, No, No." This incident was still upsetting to her. Her voice softened as she described the family's appreciation for her attempts to get pain medication for the patient. "the family,(*our bond was really good*), kept thanking me for trying and reinforcing that this is what they wanted for her."

She related that the family was quite upset the patient was not being kept comfortable. In fact, the husband became so upset he was subsequently admitted to the cardiac care unit for observation. Celine called Dr. Diamond at least three or four more times.

"She is not hurting... though he had not seen her in six hours." (*Evidently Dr. Diamond believed the patient could not feel pain because she was in a coma.*) Celine repeatedly requested pain medication. Frustrated, the family then called her family physician, Dr. Nathan for advice. She did not have privileges to write orders, but was supportive and agreed the patient should be kept comfortable. Dr. Nathan spoke with Celine and reiterated that she knew the patient did not want to be resuscitated, but would want to be kept comfortable. The family physician was supportive of the Celine's actions.

At some point, later in the day, the attending physician, Dr. Diamond called the charge nurse and requested Celine be taken off the case. "Oh he wanted me off the case. My charge nurse didn't want me off the case and she got on the phone with him and stood up for me." Eventually she assigned the patient to someone else. Although the charge nurse disagreed,

she did so to "keep peace". "This guy, his ego was so huge, it was all about control, him being in control of what this patient got or didn't get." The patient continued in pain. Celine related that, "the family told me, after he left, they were so upset, I mean visibly upset. They said that he had the audacity to tell them, to the dad, 'your wife can't feel any pain because she is not here in body anymore, she is up there looking down on you.' So he's imposing his own weirdo personal beliefs." Finally Celine told the patient's family, "ya know what, your guys could fire him. You don't have to keep him. You can get somebody else as your primary, get rid of him if you are not happy with the care. So they did."

They got a new physician who asked Celine what she wanted for pain control that would help this patient. She suggested a morphine drip which he did order. Subsequently, the patient seemed to rest better, breathing easier and more comfortable. The patient died within the next twenty four hours. "They (the *family*) thanked me and thanked me." Celine believed her interventions saved the patient undue pain and suffering. "Dealing with him was a really negative experience, but it ended up being positive . . . I learned from this experience. I think if that kind of thing happens again, I will tell the family sooner 'you can fire him (*physician*), you don't have to keep him.' ...I was a patient advocate and I feel like that is part of my job and I won't be intimidated by the doctors, or even if I am, I won't let them know it."

As an epilog, Celine was unable to attend the funeral, but called the family to offer her condolences. "It just made me feel good to know that someone is reinforcing that I did the right thing too and they thanked me."

This story represents a contrast to the five other previous stories. The first five described the sense of powerlessness the nurses felt and the resulting moral distress. Celine

however stepped forward and persevered, risking reprimand from the physician, challenging his management of his patient, she ultimately did the right thing for her patient. Her actions represented the recognition that physicians are not always in control over patient management and care. Nurses have more opportunity to control the care patients receive than they choose to do.

Chapter 5

DISCUSSION

Each narrative described an actual experience that participants identified as morally distressing and frustrating. Each nurse's story reflected a strong sense of personal and professional responsibility and commitment to their profession and their patients. Each narrative described very different kinds of situations. All six took place in an acute care setting.

When I interviewed the nurses, I expected stories about patients experiencing needless pain and suffering or end-of-life issues such as physicians refusing to write "do not resuscitate" orders, even though the patient asked not to be resuscitated. Interviews one and six were the type of stories I expected. However, in three situations (narratives three, four and five) the situations that created moral distress were problems with administrative details. Ellen was overwhelmed with too many patients and frustrated by the lack of support from her supervisor, David was upset because he felt he was not supportive enough to his staff when they were overwhelmed by admissions and Michael was overwhelmed by the excessive responsibilities of paper work and documentation (which are an important and necessary part of nursing responsibilities). These situations demonstrate that morally distressing events

occur in diverse situations and can be related to situations other than direct patient care conflicts.

Each narrative represented two common themes. First, every nurse indicated a strong sense of commitment to and responsibility for her job, both personally and professionally. The dedication to their patients was the underlying foundation of their moral distress. When those nurses were not able to provide safe, quality, beneficent care and comfort, it caused moral distress. Second, each nurse identified a sense of powerlessness in the situation they described and in some cases, they even felt responsible for events over which they had no (Mary and the patient with the bowel obstruction and Michael with eight admissions in one night). Their commitment to the ideals of nursing practice and their perceived powerlessness to change the situation created their moral distress and resulted in the emotional strain and frustration they experienced.

Moral distress involves a variety of factors which include: conflicting loyalties and obligations, conflicting personal values and beliefs, and feelings of powerlessness. Each factor challenges the nurses sense of duty and responsibility about the care she gives and the professionalism she represents.

Their stories were about the day to day challenges nurses face. They were not sensational stories about moral dilemmas. Nurses were distressed because they could not render what they believed was appropriate care and felt responsible when that care was not provided. They were conscientious and dedicated, and they worked hard to provide good care and felt the negative consequences when they could not provide adequate care, even when it was beyond their control.

The realities of the clinical situation are complex. Patients in acute care hospitals are

ill and vulnerable. Even in non life threatening situations the patient is very dependent on the skills of his or her health care providers and their hands-on care. Patients expect safe care, kindness and concern.

The nurses believed it was their duty to live up to the standards set in the ANA Code for Nurses (1985, Appendix A). They were taught in nursing school to uphold those standards and the code represented the foundation for the care nurses believed they should provide. Often, however, the reality of the clinical setting does not allow this to happen. There exists a tension between the standards of the code and the realities of the clinical situation. Clinical situations arise without much time to reflect about the right thing to do at that particular moment.

For example a patients is terminally ill and the physician refuses to write a "do not resuscitate" order. The patient tells the nurse, "I'm ready to die when the time comes and I don't want to be put on "life support". A short while later, the patient stops breathing. It is the hospital's policy and the doctor's intent the patient be resuscitated. The nurse's code requires the nurse to protect the autonomy of the patient and to respect his human dignity. The nurse professionally and personally wants to respect the patient's wishes. She knows that resuscitation requires invasive procedures such as inserting a breathing tube, inserting intravenous lines, CPR (cardiopulmonary resuscitation) and defibrilation to restore a heart beat. For a terminal patient, who is ready for death, this is not treating them with dignity, it is cruel. A nurse has seconds to decide whether to follow the patient's wishes and go against the physician and hospital policy or to resuscitate the patient as required by the physician orders and hospital policy.

Nurses manage many facets of a patient's care. It is much more than just carrying

out physician orders. Nurses are the coordinator of the care a patient receives. Nurses use knowledge, skills and critical thinking to: 1) assess the patient's physical condition (pulse, blood pressure, EKG monitoring, breath sounds), 2) evaluate laboratory tests and communicate the results to the physician, 3) administer and evaluate the effect of medications, 4) delegate and supervise care responsibilities to unlicenced assistive personnel (orderlies, nurse aids), 5) perform and evaluate the effects of treatments, 6) teach patients and families how to care for themselves (e.g. teaching diabetics how to test blood sugar, what meal plan to follow, how to administer insulin, how to recognize and treat insulin reactions), 7) provide emotional support and caring, and 8) document the plan of care, observations and patient outcomes on the patient's record . The nurse develops an implements the plan of care for the patient, while continually monitoring changes in patient condition and revising the care based on her assessment and evaluation.

Nurses continually make complex decisions. Their decision making ranges from helping a patient plan for care at home to making "split second"decisions during a crisis. The burden nurse bear is not just "life and death" in the "short run", but quality of life in the "long run". Nurses view patients as more than an illness. They see a patient as a complex interplay along a continuum of illness and wellness which is influenced by their gender, age, race, religious beliefs, occupation and the personal relationships they maintain (family, work, community).

What a nurse perceives as morally right or wrong in patient care situations depends on their personal values and the standards in the eleven statements of the American Nurses Association Code for Nurses (1985) (See Appendix A). According to the code, duties include patient advocacy (Statements 1 through 3), personal responsibility for competent

practice (Statements 4 through 6), commitment to continuing education (Statement 7), high standards and integrity of the nursing profession (Statements 8-10) and a commitment to meeting the health care needs of the public (Statement 11). A nurse thus expects to be committed to their profession, employer, patients, the other healthcare team members (physicians, pharmacists, social workers, chaplains, dietitians, physical therapists), and the entire community. These are enormous expectations. Nurses protect patients' autonomy by advocating for the right to make their own choice about treatment. This requires the nurse to be truthful about treatment and its expected effect on that particular patient. The nurse is loyal to the patient (although she must balance with her loyalty to the physician, the employing institution and her peers). The nurse advocates for quality, caring patient care, prevents harm and unnecessary suffering and insures fair treatment of patients by the system they have entrusted their care to.

It is inherent in nursing and medical care that one practices with honesty and integrity in providing appropriate care to everyone. Morality is influenced by personal values and by values learned from formal education. Nurses incorporate the tenets of the "Code for Nurses" (1985) which states that nurses must respect human dignity, protect privacy, protect patients from incompetent, unethical practices, and be responsible for their own actions. Nurses must also collaborate with other health professions to meet public health needs and to maximize the quality of life.

Nurses need to know and understand the standards set forth by their profession (Raines,1993; Scanlon & Glover, 1995). Understanding provides a foundation to direct and guide their professional practice. Corley, (1993) Raines, (1993), and Scanlon and Glover, (1995) noted that the American Nurses' Association, Code for Nurses (1985) is the basis for

the conscience of nursing. They emphasize, first the conduct of nurses in their care of clients that includes, autonomy, beneficence, non maleficence, veracity, confidentiality, fidelity and justice. Second they mention the competence of nurses. "Professional nursing is regulated by standards that specify the conduct of practitioners and hold them accountable for failure to uphold these standards (Raines, 1993, p. 614)." Raines emphasized that the standards are lofty and "...the applications of these principles as absolutes is impossible. The practice of nursing involves people, human relationships, and individual virtues, not abstractions (p., 539)."

I believe that all the nurses who were interviewed wished to uphold the standards of nursing care. The standard for patient advocacy was particularly evident in narratives one, two, three and six. Briana , Mary, and Ellen were advocates for the welfare of the client; Briana to allow the patient to die peacefully and comfortably, Mary to intervene before the patient suffered a bowel obstruction, and Ellen to have adequate staff for the patients she was assigned. All tried to intervene in behalf of the patient, but were overruled by someone with more authority. Celine persevered and succeeded in getting pain medication for the patient. She expressed positive feelings about her advocacy. It took a lot of phone calls, time, and energy. She persevered. She followed through with what she believed was right and the patient benefitted as a result.

Others directly (physicians) or indirectly (third party payers) control care, but that care may not appear to be in the best interest of the patient. At times, physicians may direct care that seems to cause more harm than good. The physician expects the nurse to follow his orders, the hospital usually supports the physician and the nurse perceives herself in a "one down" power struggle. These power imbalances (physicians and administrators wield more

power than do nurses) and conflicting loyalties (to the patient, the family, the institution, the physician) create tension in the nurse's professional practice. Nurses struggle between responsible patient care, following physician orders, the policies of the institutions and the law. Wilkinson (1989) suggests that conflicting loyalties can occur when nurses are close to patients. A nurses primary responsibility is to her patient and yet she has responsibilities to families, employers, and physicians. She needs to answer questions and concerns the family has, she must follow policies of the institution and follow the orders the physician may write.

Insurance companies deny payments for care that may be beneficial, but are deemed too costly, such as bone marrow transplants. In addition, insurance companies dictate care through levels of reimbursement. They may require early patient discharge or refuse certain treatments. Sometimes employers ask nurses to care for more patients than physically possible and professionally safe. Often the nurse becomes angry and frustrated and may believe there is no one to support her.

As written in Cunningham, (1993), Doka, Rushton and Thorstenson, (1994), and Daniel, (1998), state that powerlessness is created in some acute care situations. Nurses feel overwhelmed and it influences their ability to give care. The perception of powerlessness originates form a variety or causes. Benjamin and Curtis (1992) identified that physicians are at the center of decision making and that the nurse acts as a "passive recipient." Patient care is under the direction of physicians and nurses do follow their orders. Erlen and Frost (1991) concluded that nurses saw themselves as powerless. Brody (1992) pointed out that gender may be an issue when physician are men and the nurses are women. He wrote that the "relationship between men and women is basically a disparity in power, with men having the social status and control necessary to maintain their privileged power status" (p. 28). Two

of the narratives may have represented this gender issue. In Briana's case (the burn patient) and Celine's case (the dying patient), the male physicians seemed to hold some power over each nurse that prevented her from doing what she believed was right. Briana could not convince the physician to write a "Do not resuscitate" order. Celine went against Dr. Diamond's directive, but he succeeded in having her removed as the nurse caring for his patient.

Other instances of powerlessness occurred when Mary attempted to get the physician assistant to keep the patient in the hospital. Ellen and Michael tried to keep their supervisor from admitting any more patents. Mary attempted to advocate for the patient, while Ellen and Michael were advocating for patients and colleagues. All expressed anger and frustration. They all felt morally responsible for the outcomes they had no control over.

Mary struggled with guilt because she believed she was responsible for letting the patient go home too soon and the patient subsequently developed a perforated bowel which required weeks in the hospital. I do not believe anyone blamed her for the patient's outcome, but she felt responsible for a situations she was powerless to prevent. Ellen believed she was powerless to stop the patient's admission to her already overwhelming patient care situation. Michael believed he was powerless to stop eight admissions in one night or to keep his staff from getting discouraged and quitting. David believed he was powerless to the stop the necessary paperwork from eroding his time away from his patients. He struggled with the fear he would miss something or make a mistake.

Powerlessness is an important component of moral distress, however it is not the only component. The sense of duty and commitment to patients is woven into the foundations on which nursing is based. A nurse's personal and professional sense of duty and perception

about what they ought to be or do is also a key component which determines the situations that create moral distress. The feeling of distress is magnified by the sense of duty and commitment nurses have to their patients and this may conflict with their sense of duty to the institution that employs them, the physicians who write the orders, and their peers who depend on their support and guidance.

Nurses do follow most physician orders and most would agree not to follow orders that would harm the patient. For example, if there is a dosage error or the wrong medication is ordered, nurses would never give the medication, she would call to clarify the order. There are times when the determination of "rightness" in following physician orders is less clear. For example, in Celine's story the patient who is refused adequate pain medication. What if a cancer chemotherapy treatment is ordered for a patient and the nurse knows that it offers no benefit to the patient and the patient has not been informed about the severe side effects and negligible benefit? The nurse knows that the treatment will cause suffering and no benefit. Should the nurse follow the physician's order or disobey it when she feels it is morally wrong? She risks reprimand for not following the order, she risks watching the patient suffer for following the order.

The complexity of moral issues in health care is mind boggling. Situations such as those described above should not be confused with other instances where nurses may still feel powerless, but do not necessarily create moral distress. Nurses are faced with life and death situations. They cannot prevent an inevitable death or prevent the pain of walking again after pelvic fracture in a car accident. Yes, they experience feedings of powerlessness in those situations, but they do not suffer moral distress. In those situations nurses are able to accept the inevitable. However, in circumstances where they believe they could have or should have

made a difference, they feel distress.

Nurses feel responsibility to patients, their profession, the agency they work for and to the physician. As Doka, Rushton and Thorstenson (1994), noted, with a multitude of loyalties, internal conflict can occur. It is the strong sense of duty and the high standard nurses set for themselves that create a strong sense of obligation to those they serve. That obligation is intensified because nurses deal with life and death situations on a daily basis and the people they serve are vulnerable.

Sometimes principles conflict. A patient, for example, could ask a nurse to assist in a suicide. Should a patient's autonomy be respected by the nurse in this situation? Nurses cannot break the law to support patient desires. A patients autonomy is not absolute and may need to be overridden in some circumstances. Patients are customers who intrusted their care to health care professionals. Professionals have an explicit moral obligation to their patients. The society they serve expects this obligation and this is confirmed by the medical and nursing professional code of conduct. Professional nurses publically promise to care for patients with competence and to protect them when they are ill and vulnerable.

It is the lack of resolution of issues and the feeling of powerlessness to change the situation that frustrates the nurse. The energy it takes, the time (in an already busy day) and the uncertainty of a reprimand or negative outcome leads most nurses to take the path of least resistence and simply "forget it and move on." Sometimes the feelings of distress remain turbulent under the calm surface of "business as usual". Nurses need a forum where they can discuss the moral principles or issues, explore their values and biases, vent their doubts and frustrations, consider alternatives and seek problem solving opportunities. Understanding interpersonal differences, learning moral principles, sharing experiences and successes may

empower people to follow their convictions and alleviate moral distress.

Benoliel (1993), Corley and Raines (1993), Cunningham, (1993), Daniel, (1998), Doka, (1994), Fowler (1993), Perkin, et al (1997), and Taylor, (1993) indicated that moral distress was a common experience for nurses. What made it noteworthy was its negative consequences such as anger, frustration, feelings of powerlessness, job dissatisfaction and even leaving nursing altogether. Corley (1998) wrote that "(t)he impact of moral distress on nurses is responsible for 13% of those who have left nursing positions in the past and in 5% of those who have left the profession" (p.325).

The sense of commitment to do what is right is an important part of the complete package ascribed to nursing care. Society expects nurses to be devoted care givers and protectors of the vulnerable patients in their care. I suspect society does not recognize the moral distress nurses experience with their jobs. Corley and Raines (1993) reported that fifty five percent of nurses reported conflict between personal values and professional values. There is little doubt that most nurses experience distress when they believe they have not supported or protected their patients the way they believe they should. The emotional connection nurses have with patients includes comforting patients and families who are often fearful and apprehensive about being in the hospital. Patients often rely on the nurses for this emotional support. A nurse may assume responsibility for her patient's physical, emotional, and spiritual well-being. When something interferes, such as lack of time secondary to work load, unreasonable physician orders, or extensive paper work, nurses can experience moral distress.

Moral decision making is influenced by the heath care providers wishing to do what they believe is the "right thing" for the patient. Whether the right thing is to implement all the

technology and medical knowledge to maximize the moments of physical being or to step back and breath in the essence of the patient as an individual with desires and wishes about quality and quantity of life.

Other professions such as airline pilots, school bus drivers, airplane traffic controllers all have tremendous responsibility for the people in their care, but I do not believe they experience the day-to-day moral distress nurses experience. Nurses face life and death situations regularly and have direct physical contact with the people they serve. Patients trust that nurses will care for them. Such responsibility is expected by each nurse, by other nurses in the profession and by society. Nurses realize that a mistake or miscalculation on their part could (although seldom does) cause great harm or death. Medicine and nursing are not an exact sciences. Patient care and life and death situations are fraught with uncertainty. One can practice good medicine/nursing and have a bad outcome. For example, the young burn patient received good care, but no one could prevent his inevitable death. Such situations occur and we are powerless to change the outcome, but there can be room for self doubt. We wonder if there was something more we could have done.

The nurses' workload and the critically important care they provide often prevent time for reflection on the distress they are experiencing. Because of the nature of the job, the nurse must continue to care for her multiple patients and merely "stuff" the negative feelings. The frustration builds, the nurse becomes disillusioned and changes jobs or leaves nursing. Corley (1993) identifies that "ineffective coping with moral distress included crying, sarcastic retorts, withdrawing or going along with the situation, considering resignation"(p. 281). Benoleil (1993), Fowler, (1993), Winters (1993), Wocial (1996), Corley (1995), Doka (1994), Curtin (1994) claim that professional, personal and societal values set the stage for

moral distress and the power that prevents nurses from doing the right thing for the patients they serve. The authors all express concern about the frustration that leads to dissatisfaction and leaving nursing as a career.

The nurses in this study described the sequella of their moral distress. The distressing events created anger and frustration at the time it occurred at work, but some noted the lingering effects that blended into their personal lives. David felt anger was becoming problematic in his personal life. Ellen suffered from insomnia. Michael believed his anger and frustration was a negative influence on other nurses he supervised. Moral distress is a personal and private issue. Distress can be cumulative and it can leach into ones personal and professional satisfaction with life. These issues are complicated by the lack of clarity about what the moral issues are, our own sense of values, what the patient's best interest is, how far the professional duties or responsibilities go and how powerless the nurse is (or believes she is) to change or rectify the situation.

The hands-on care a nurse provides establishes an intimate connection between the nurse and the patient. When patients suffer, nurses see and hear the patient's pain and suffering first hand. It makes it more difficult when the nurse sees care that she knows is adding more pain and suffering than therapeutic benefit. It is one thing for physical therapy to cause some pain if it means the patient will regain use of their legs and resume normal functioning, but it quite another for the nurse to follow a physician's order to continue physical therapy on a patient who is imminently terminal, extremely fatigued and suffers severe pain during therapy. In the latter case, the patient's suffering serves no useful purpose.

Values and beliefs originate from teachings and experiences throughout a lifetime; teaching from family, religion, education, job experiences, peer group mentoring, as well as

ethnic and cultural factors. "We recognize that ethics are framed and rooted in political values, laws, and a legal system; but ethics also are rooted in our own personal biographies and values. As such, they are influenced by our culture and our religious values (Doka,1994,p. 346). Beliefs and values are multi faceted. Values tend to remain stable over time. Beliefs are influenced on a continuum over time and experience. As life experiences occur they change the way one sees the world in which they live.

There are times, especially with inexperience when the nurse is uncomfortable with morally relevant care issues. As the one mentioned above, the nurse may be uncertain or ambivalent about the situation and its outcome. It is critical for the nurse to explore her values and beliefs and to seek support from colleagues and discuss these morally relevant situations. There may be times when nurses experience uncertainty about patient care issues as well as moral uncertainties related to patient care situations. Nurses in these circumstances should seek mentoring from nurses who have more experience in these circumstances. These mentors can offer guidance for those disconcerting situations.

Self awareness about one's values and beliefs is important. One must integrate experiences from social, familial, spiritual, political, professional and educational influences. What we know (or believe) to be true does not necessarily agree with what we feel or want to believe. For example, what if Briana's burn patient had been a "do not resuscitate", but she believed that patients should be kept alive at all costs. She knows that should the patient stop breathing, she should not call a "Code Blue" to summon the resuscitation team. She would feel moral distress because of her personal beliefs.

One cannot prevent moral conflict from occurring. Each event is perceived through our own eyes. Each event may not be able to be remedied but it is important to hear the

voices of different nurses describing different events to acknowledge that moral distress is a common occurrence in day to day nursing care and that it is related to the timing of an event and/or the context. Events causing moral distress are not just sensational cases such as when a seventy-nine year old man, fourteen years beyond the accepted standard, is given a donor heart transplant or end of life decisions where individuals such as forty-five year old with end stage, terminal lung cancer is put on life support.

Distress can be related to the timing of an event and/or the context. One nurse cannot change all the causes and effects of morally distressing situations, but should be encouraged to take some action, however small. She can tell the physician how she feels and why she believes it is not in the patient's best interest, she can document incidences of "short staffing" and meet with her supervisors to let them know the effect short staffing has on patient care, or appeal to the insurance company case managers when reimbursement is denied for necessary treatments. She must choose her battles wisely. Barry Adams a nurse from Massachusetts was fired when he "raised concerns about his hospital's deteriorating conditions and reported dangerous staffing levels (Michigan Nurse, p.13)." He believed that safe care for his patients was worth losing his job. Not every nurse would risk losing their job. The nurse should know what values she is willing to stand up for and "the price" she is willing to pay. It may mean transferring to a different department or leaving a particular institution. If enough nurses take action, their voices will be heard. Saying "it's no use" or "why bother, it won't make any difference," will only serve to create burnout and further exodus of good nurses from the health care system that depends on their clinical expertise, compassion and commitment to quality patient care.

As Whitbeck (1996, p.9) stated, "Moral problems are not multiple choice–problems.

One must devise possible courses of action." Nurses can identify the problems and should develop a system in which they can problem solve or at least share experiences and receive support and empathy from others. An example of such an opportunity was a program called "Ethics Brown Bag" which is held at a local hospital. Ethics Brown Bags are one hour, monthly presentations on a topic related to medical ethics. Topics may include a discussion about a clinical situation, a case presented to the ethics committee or informational presentation on moral principles. Its focus is education and discussion of a timely topic on ethical issues. The program I am highlighting was titled "Moral Distress: A Problem from the Inside Out or the Outside In". There were twenty five participants from a variety of health care professions. Approximately half were nurses, the other half were social workers, chaplains, physicians, a laboratory technologist and a sociologist. The facilitator first offered a definition of moral distress and a brief description of how she was influenced by moral distress in her own practice. The hour long discussion followed about whether people experienced moral distress because of who they are and the values they have, or did they experience distress simply because they worked in a healthcare environment that offered opportunities for morally distressing events. The consensus was that both factors were integral in developing and relieving moral distress.

Participants were encouraged to describe how moral distress influenced their practice. The responses were touching and sincere. One man, a sociologist observed, "(w)hen we have an identity (as a professional), taking away our decision making makes us frustrated; we loose our autonomy." When we watch a patient suffer because we have too many patients under our care and must see one, as Ellen described, lying in her own "poop", we experience moral distress. We know the patient deserves a clean bed, yet at that moment we cannot

provide what the patient needs.

Another nurse described the sadness she experiences when staffing on the night shift forces a nurse to abandon an opportunity to sit with a patient, to hold a hand, to listen to a patients's fears about leaving three small children and a husband because she will soon die from breast cancer. This nurse made the point that these opportunities often present themselves in the middle of the night when all the visitors are gone and the patient has quiet time to reflect.

Each participant had touching scenarios to share. As the hour came to an end, everyone agreed they were grateful for the opportunity to share their morally distressing experiences, to hear ways of successfully handling such experiences, and to share how the experiences helped them grow. The discussion was helpful in relieving some of their distress and helped them realize their experiences were not unique. Many participants thanked the facilitator for the opportunity to share their stories and suggested more meetings such as this one would be beneficial.

I believe that institutions could easily implement discussion groups similar to the Ethics Brown Bag forums. It should be a regular ongoing effort and it would cost very little to implement. The institution could provide the space, recruit a group discussion leader, and offer the program during lunch or break times so it would not be "paid time." The facilitator would help guide the discussion, allowing participants the opportunity to speak freely, yet to be respectful of other's viewpoints. Participants would also be assured that their comments would be kept confidential to allay fears of a reprimand. Concerns of the participants would be summarized at the end of each session and concerns shared with administration as appropriate.

Brown Bag Discussions would provide an opportunity for nurses to share their morally distressing experiences. The group would allow nurses the opportunity to vent their frustrations and provide a therapeutic environment to relieve stress in the short term. Many times just talking about difficult situations and receiving support from one's peers can be helpful.

Another option would be collaborative work groups that would be established to make changes in policy or correct behaviors that are unacceptable. These groups might include nurses, physicians, administrators, and/or ethicists who would meet regularly to create innovative solutions that serve to decrease the number of morally distressing situations. They may focus on situations such as improved staffing ratios or establish mentoring/counseling for care providers (physicians, nurses, administrators or other health care professionals) who cause or potentially cause suffering to their patients (e.g. refusing adequate pain medication for a dying patient). Hopefully such options would improve working relationships, reduce morally distressing situations, improve job satisfaction and improve patient care.

Working within a hospital system, nurses might consider three ways of managing moral distress. One (which I believe is unacceptable) would be to lower the standards expressed in the Code for Nurses. Lowering the standard would not only effect the quality of care, but damage the trust and faith people have in the nursing profession. To lower the standards of the nursing profession in order to lessen moral distress would not be appropriate.

A more reasonable possibility might be for nurses to take more risks by confronting the situation or issues that create moral distress. An example of risk taking behavior was modeled by Celine when she challenged the physician's unwillingness to prescribe pain

medication for his dying patient. Nurses can make a conscious choice to challenge a physician's order or administrative policies when the welfare of the patient could be adversely affected.

A third, but rather idealistic choice, would be to give nurses the resources and authority to perform their jobs at the same level of authority accorded physicians and administrators. It should be a situation where nurses do not fear retribution for challenging a physician's order or a supervisor's unreasonable request to take more patients. Care and management of that care would be provided in a collegial milieu where the judgements and decisions of each discipline could be heard and considered equally.

Chapter 6

SUMMARY AND RECOMMENDATIONS

I have gained a better understanding about the moral distress of nurses. Noteworthy was the fact that most nurses were not familiar with the term moral distress and had not really explored solutions to relieve their distress. I realized that moral distress involves aspects of nursing care other than end-of life moral dilemmas. Moral distress emanates from an intense sense of duty and responsibility to the patients they serve and the profession they represent The sense of duty and responsibility is very powerful and coupled with a belief of powerlessness, nurses experience moral distress. David, Michael, and Ellen still felt the anger from their past distressing events. Mary felt guilty about her patient's suffering. I believe we, as a profession, must help nurses cope with their moral distress and support them when they are faced with situations where they have no control or perceive they have no control. When they cannot achieve the standards in the Code, nurses must realize that the Code is not the

problem. It is the situations that requires the nurse to perform contrary to or to a lesser standard than the Code allows. Nurses must help each other cope with distress.

Moral distress causes people to suffer. They suffer from anger and frustration and they suffer from job dissatisfaction because they cannot do the job they believe they are supposed to do. Sometimes the "right thing to do" is not clear, but intuitively the nurse believes "the wrong" is being done. There can be many obstacles to doing the right thing. The Code for Nurses serves as a guide to the kind of professional a nurse should be, but there are limits to such standards. The standards are not absolutes; to accomplish all is often not possible. Sometimes the autonomy of a patient, such as seeking a heart transplant at seventy-nine, should not be supported. Admitting a third critically ill patient might be good for the one patient, but when it jeopardizes the care of two other patients, it should not be done. Interpretation of the standards as absolutes ultimately sets the stage for moral distress.

A nurses responsibility to the Code for Nurses is complex. We want the nurse to uphold the standards set forth by the Code for Nurses, to be confident that they are competent, caring, truthful, fair and promote public health. In the hospital, the nurse spends the most of the time with the patient and learns from the patient what is important to them, administers the care, teaches him about the treatments and expected outcomes. The nurses are the ones closest to the patient. Perhaps this close contact with the patient makes nurses more vulnerable to moral distress.

Nurses will continue as patient advocates, but they must recognize the conflicts that occur with that role and the emotional sequella. If they recognize the phenomena of moral distress in themselves and others, they then can establish more dialogue about the particular situations and seek support and understanding from each other. Nurses do not usually

recognize their own distress. They do not nurture themselves or their colleagues during distressing events. David was told by his co-workers, "that is what nursing is, you have to expect it and if you're called to do it, you just do it and you get through it." or "People tell me to lighten up." I believe these comments are common. Nurses are so often caught up in the hectic pace of patient care and we do not take time to hear the frustrations and support each other enough.

It is important to see moral distress as commonly occurring and ongoing issue for nurses and that the result can be disillusionment with nursing as a profession. Like the metaphor, "It's not the height of mountain we are climbing, but rather the grain of sand in our shoe that wears us down." It is the day to day distress that creates the disillusionment.

Nurses need to support each other when they advocate for their patients and/or their peers. The voice of many, supporting the rights of others is always more powerful than a single voice. Nurse should not feel alone when faced with morally challenging situations. Seeking support and understanding, nurses can work together to forge better solutions. Better solutions would support better job satisfaction and create less burnout. Through increased awareness of nurses' moral distress, disillusionment can become enlightenment.

I hope this paper has made more visible the morals distress nurses experience. This research has merely scratched the surface of the stories that nurses could tell. Future research on moral distress could include nurses from other acute care areas (pediatrics, labor and delivery, critical care) and explore whether they too experienced similar feelings of powerlessness and professional responsibility. Nurses working in public health, home care, long term care facilities (e.g., nursing homes), or hospice should be interviewed to see what issues create moral distress for them.

Another interesting prospect for further research would be to interview other health care professionals and then compare similarities or differences among each discipline. It would be interesting to learn about the moral distress physicians, medical social workers, dietitians, or physical therapists. Perhaps this paper will encourage further research about health care related moral distress.

Appendix A

American Nurses Association Code for Nurses
(1985)

1. The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgements and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Appendix B

Consent Form

My name is Linda Harrison, I am working on a study that will be the basis of my Masters Thesis in Interdisciplinary Program in Health and Humanities. You have been asked to participate in a study exploring the meaning of a situation related to patient care where you knew the right thing to do, but felt that politically or socially you were not able to act titled "A Narrative Study About the Effects of Moral Distress on Nurses Caring for Adult Patients." You will be asked to briefly describe the situation and what this event meant to you, how it has affected you, and how the situation was ultimately resolved. The first interview will take no more than forty-five minutes. A second, shorter interview may be required within the next three to six months to clarify or enhance the information revealed in the first interview. This information will be interpreted by the researcher for purposes of the study.

There are no risks or costs to you as an individual. All discussions and your identity will remain confidential. You may refuse to answer any questions or volunteer any information that makes you uncomfortable. You may stop participation at any time in the interview process without any penalty. After interpreted, the audio tapes will be erased. By voluntary participation in this study you are consenting to the use of information from the interview to be used later as part of possible published research. There is no risk to you whatsoever by participation in this study.

If you have any questions or concerns related to participating in this study you may contact; **Principal Investigator, Jacob Climo, PhD, Professor, Department of Anthropology at 517-355-0189, Linda Harrison, RN, BSN, Investigator at 517-339-0591 or UCHRIS (University Committee on Research Involving Human Subjects at Michigan State University) chair, David E. Wright at 517-355-2180.**

Signature _____ Date_____

Linda Harrison, BSN
Masters Candidate
Michigan State University
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