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GUILT AS AN ELEMENT OF MORAL DISTRESS IN NURSING PRACTICE

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ABSTRACT

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By

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Today's nurses experience moral distress in the routine practice of nursing. A small body of research into this phenomena, mostly dating back to the 1970's and 1980's, defines the moral distress of nurses as frustration and disappointment owing to their conflicting loyalties and responsibilities. An examination of current nurse narratives reveals the presence of feelings of guilt and shame as nurses struggle to reconcile their own behaviors in a complex healthcare delivery system. After establishing the presence of guilt and shame in the voices of some nurses, an explanation for the past omission of guilt and shame is offered. Finally, some thoughts are offered on the direction of further research in this area.

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INTRODUCTION

Ethicists and nursing scholars have begun to examine nurses' expressions of moral pain or suffering in the routine practice of nursing. This suffering, commonly referred to as "moral distress" in a small body of scholarly literature on the topic, has been characterized as frustration, anger, sorrow and resentment which arises when nurses are unable to do what they hold to be the morally correct thing. I contend the existing account of moral suffering by nurses is incomplete without a clear description of the guilt expressed in the narratives of nurses. I will argue that nurses' moral suffering can, in addition to the existing descriptions of "moral distress," be described as a crisis of conscience as nurses struggle to retain integrity in the face of difficult, challenging circumstances.

After establishing a clear definition of the term "moral distress" and its applicability to nurses, I will examine the scholarly literature on this topic, noting its universal disregard of guilt. Next, I will explore the nature of guilt and shame and the role of emotions in ethics and moral wisdom so that we will know what we are looking for. Then I will explore narratives by nurses and provide an analysis of their "voices." I have selected poetry and stories by nurses, published as literature, to show a sense of guilt clearly present within the moral experience of nurses. I will also identify a genre of nursing stories I refer to as "moral hero" stories, which I contend reveal moral discomfort and implicit knowledge of moral agency nurses sometimes fail to exercise. Using other evidence, I will show that guilt not only exists in the experience of nurses, but also may be widely felt. Once having established guilt as an integral part of nurses' "moral

distress", I will offer an explanation as to why guilt has been omitted or ignored by others.

Lastly, I will highlight the significance of establishing a clear and accurate understanding of "moral distress" in the U.S. nursing experience. My overriding goal is to point others in the direction of guilt as a key component of the moral experience in nursing. I will additionally offer some ideas for further work in this area.

DEFINING MORAL DISTRESS

"Moral distress" is a term I will use throughout to describe feelings of anger, frustration and resentment associated with moral perceptions. These feelings are always described as irritating, agitating or causing disequilibrium. It is said to affect many types of healthcare practitioners and certainly others outside of healthcare, as well. The experience is not unique to nurses. Nurses frequently encounter situations involving patient care in which they believe they have a responsibility to address ethical issues. Undoubtedly, in any situation involving patient care, a nurse's experience and perception of the available options will be a factor in dealing with ethical issues. It follows that the nature of the moral distress any given nurse encounters will depend upon the depth of understanding that comes with experience. Moral distress is that condition in which a person experiences a perceived or real inability to take an action or a course of actions believed to be morally correct.

In the literature on moral distress, most of it from studies conducted during the 1970's and 1980's, obstacles to nursing action have been described as (1) value conflicts with a more powerful medical profession, (2) institutional constraints such as short staffing issues, lack of administrative support, ostracism by physicians or administrators, fear of job loss, and (3) legal limitations such as inadequate authority in treatment decisionmaking. Nurses have identified these constraints as acting to interfere with their perceived ethical obligation to their patients (Jameton 1984; Wilkinson 1988; Lamb 1985; Rodney 1988; Decker 1984).

Unresolved moral issues in nursing practice contribute to a sense of moral compromise and moral distress. One of the most frequent moral dilemmas described by nursing involves "prolonging life with heroic measures" (Davis 1981; Wilkinson 1988; Fenton 1987). Typically, nurses have reported incidents of prolonging the death of terminally ill patients with unnecessary tests and treatments or failure to offer treatment withdrawal. Other versions of "end of life" issues involve truthtelling or a decisionmaking process leading to needless suffering on the part of patients and families. A case which may serve to exemplify this type of moral distress would be a nurse caring for a dying patient with orders for hourly lab draws. The nurse believes these tests and tasks are futile and interfere with her ability to provide for the patient's comfort. The physician refuses to discontinue the tests. The healthcare administration balks at addressing the frequent testing and refuses to intervene. The nurse knows the tests are senseless and contribute to increased suffering for the patient. Stopping the tests would antagonize the physician and the administration. The nurse may even feel concerned about anger or retaliation becoming displaced onto the patient.

Technically speaking, however, there are other options she might pursue, e.g. reporting this to the medical chief of the department or the administrator in charge of the department. The nurse could, in many of today's institutions, request a consultation with the institutional ethics committee or simply encourage the patient's family to question the testing. Still, any of these options may serve to irritate the physician or administrator. This nurse feels forced to participate in an action she believes to be wrong by virtue of being required to draw the blood specimens. This nurse is experiencing moral distress.

Moral distress as an experience of nurses might be distinguished from a physician's moral distress in terms of the ways in which relief can be found. Consider the following scenario: the physician is distressed because he or she believes the patient should have a screening colonoscopy. The patient's mother died of colon cancer and a colonoscopy might detect early signs of cancer. However, screening colonoscopy is not covered by the patient's health insurance policy. The physician has a luxurious option nurses do not share. He or she can lie to the insurance company. The test will be covered by the patient's insurance policy if the physician orders it as part of a workup for "rectal bleeding" or "abdominal pain – etiology undetermined." Physicians can and do relieve this type of moral distress by lying (MSNBC 1999). The physician's moral struggle is generally more about getting the treatment for the patient, as opposed to the nurse who must actually take an action or participate in actions toward the patient.

I have given a basic description of moral distress: a sense of being thwarted from taking an action one believes to be morally correct, with accompanying feelings of frustration, anger, disequilibrium. In the next section, I will examine the scholarly literature on this phenomenon.

LITERATURE REVIEW

The description of moral distress as troubling the nursing profession began with the work of Andrew Jameton (Jameton 1984). Jameton made distinctions among the concepts of "moral uncertainty" (questioning the morally correct action), "moral dilemma" (faced with morally conflicting actions) and "moral distress" (inability to take what one perceives to be the morally correct action). Jameton argued that the moral distress of nurses arises from institutional constraints resulting from conflicts among constituencies (e.g. medicine, administration, law, etc.). Most of the subsequent work on the issue of moral distress among nurses has followed Jameton's definition.

Fenton (1987) and Rodney (1988) studied the sense of moral distress among critical care nurses in the early 1980's. In both these studies, the nurses reported feelings of sadness, anger, resentment, frustration and sorrow experienced as a result of an inability to act on their moral decisions. Lamb's 1984 thesis (Lamb 1984) reported a similar range of emotions and found, as well, a desire for revenge upon other healthcare decisionmakers who thwarted nurses' efforts.

These researchers describe the experience of moral distress for nurses as a disturbingly painful sense of disappointment, sadness, frustration and anger. Commonly, the focus is on the actions of others, specifically the other that thwarts the action of the nurse. However, a few nurses in Wilkinson's 1988 study reported feelings of guilt and shame. These nurses questioned their own autonomous rights to action, i.e. "Do I need to push this? What will be the outcome if I don't? Will the child live?"

Most of the ethics literature on nursing indicates a deep rift between the moral conceptions of nurses and those of physicians. The literature speaks of several kinds of things that interfere with moral action of nurses. These include the hierarchical structure of authority in a hospital and systematic disagreements between professions about values and habits among physicians of not noticing or of discounting the moral position of the nurse. Corley's 1995 publication of a study of moral distress among critical care nurses and made the following observation:

> The conflict between commitment to the organization and commitment to the patient, as well as conflicts in values between physician and nurse, can produce moral distress or suffering for the nurse. 'If the distress is unrelieved, the nurse's self-worth is jeopardized, personal and professional relationships may be affected, and psychological changes, behavioral manifestations and physical symptoms may occur.' (Corley 1995, p. 281)

Corley describes moral distress for nurses as anger and frustration largely associated with conflicts of values with physicians and resentment about patient care conflicts of a moral nature between nurses and physicians.

Along these same lines, Chambliss' work (based on intermittent observations of nurses between 1979 and 1990) reported nurses strongly objected to the "learn-by-doing" practices in teaching hospitals, in which new interns and residents frequently perform procedures for the first time on the very ill or the very poor (Chambliss 1996). Chambliss further observed that nurses resent the perceived imbalance of care provided by physicians to the "...new, the rare, the extraordinary and dramatic medical cases," as opposed to that afforded to the more "routine" or less "prestigious" cases/patients. Chambliss' field research in U.S. hospitals led him to conclude that it is the intense

witnessing of patients' suffering that leads nurses to advocate for palliative care, while physicians generally favor more aggressive and more risky treatment.

Benjamin and Curtis (1987) do not describe moral distress explicitly but, like Jameton, they describe the moral actions of nurses as being blocked by constraints on their practice,

> ...the hospital nurse finds herself constrained in various and occasionally conflicting ways by the hospital (which employs her), the physician (with whom she works), the client (for whom she provides care), and the nursing profession (to which she belongs). To what extent can she be her own person - i.e., be ethically autonomous - in these circumstances. (Benjamin and Curtis 1987, p. 182)

This perception of nurses' inability to act freely, to take action in terms of moral decisions, is viewed as somewhat insoluble by Benjamin and Curtis:

> We have no simple solution to the problem of free action in nursing. On the one hand, we admire nurses who risk punitive responses from physicians and others for the sake of patient rights and their own moral integrity. We think such nurses should generally be commended and supported. On the other hand, we recognize that many nurses face situations in which it would be extremely difficult to withstand the threat of punitive responses. Moreover, we do not believe that nurses should have to be heroines or make harsh personal sacrifices to do what they have good reason to believe is morally right or to preserve their moral integrity. So the nurse in this case may simply have to make the best of a very bad situation. (p. 186)

This perspective emphasizes that a nurse's range of moral actions is regularly constrained. For Benjamin and Curtis, autonomous moral action on the part of the nurse is a consistent challenge.

Nelson (online) has described moral distress among nurses as "...arising from restriction of the freedom to exercise one's moral agency." Nelson gives the following

case example describing the nurse as being *dismissed*, morally speaking, in professional practice:

> A 15-year old boy, Jake is dying of cancer, but his mother insists that he not be told, and Jake's oncologist leaves orders to that effect for the nursing staff. Pilar Sanchez, one of Jake's nurses, is very troubled by this and judges it's wrong to withhold the prognosis from her patient. She raises her concern with the oncologist but he writes her off as an emotionally over-involved nurse who is also an excitable Hispanic. Her concern, in other words, doesn't get registered as a "moral" concern at all. As a result no care conference takes place and Pilar fears she might make matters worse for Jake if she takes matters unilaterally into her own hands. So she feels awful. In fact, she feels moral distress.

This is typical. Nearly every description of moral distress in nursing points to feelings of anger and frustration stemming from the inability of nurses to take an action believed to be morally correct. This inability to take an action, to exercise one's moral agency, has been attributed to "obstacles" to action (Jameton 1984), value conflicts with others (Corley 1995; Chambliss 1996), constraints that thwart or block nursing action (Benjamin and Curtis 1987), or restrictions that essentially dismiss the moral concerns of nurses (Nelson 1998). I contend that in framing the problem of moral distress in this way, these accounts omit or suppress the implicit moral authority that nurses understand as their own, the very kind of personal authority or responsibility that underlies expressions of guilt.

The basis of my claim is that guilt is present in the distress some nurses experience around moral issues. Guilt is an emotion we associate with pain or suffering. Before we attempt to explore expressions of guilt in nursing narratives, a brief examination of guilt and the role of emotions in moral considerations will help clarify what is revealed about nursing in the narratives.

WHAT ARE GUILT AND SHAME?

Guilt is the unpleasant emotion (simply defined as a physiological sense of arousal accompanied by a belief or conviction) one feels when one fails to obey some "rule" or precept one has accepted as important. It is a self-directed form of discomfort at the thought of being responsible for a wrong. The emotion of guilt (as moral failure) may persist even when one perceives his or her failure as unavoidable.

Guilt has been generally defined as a "functional" emotion (as opposed to "dysfunctional" emotions observed, for example, in panic states or groundless jealousies or severe clinical depressions) in that it appears to serve as a prime motivator of behavior (Davidson 1994, p. 116). Humans seem to endeavor to rid themselves of guilt by taking restorative actions, to make reparation or amends. I believe guilt, or the prospect of guilt, often motivates nurses to engage in acts of "moral heroism," i.e. to advocate for patients or act on moral decisions even in the face of powerful opposition.

According to Herbert Morris, guilt involves a painful sense of separation from others about whom we <u>care</u>. Some union or relationship with another has been "ruptured" by our wrongdoing (Morris 1971, p. 62). This link between guilt and caring relationships is pertinent to the nurse-patient relationship. The nurse has a fiduciary relationship with the patient to provide "care." The work of nurses is defined as "caring" for the ill and injured. Caring is the very essence of nursing practice (Benner and Wrubel 1989). The moral worth of the nurse is commonly viewed to be proportionate with the extent to which he or she "cares" for patients. Nurses are esteemed for their displays of caring behaviors to patients. The emotion of guilt is dependent upon a relationship with

others that is valued. "Part of what it means to care for another is feeling pain in circumstances where another is pained. And part of what it is to care for oneself is to be pained at the hurt done oneself by the hurt done others." (Morris 1971, p. 63) When nurses witness or participate in actions they believe contribute needlessly to the suffering of patients, they feel distressed.

Shame, a concept closely related to guilt, is a condition of disgrace. It involves being compared to a certain model identity (Rawls 1963, p. 132). Unlike guilt, in which a relationship is necessary, shame involves a question of being or appearing worthy. We feel shame in situations in which we have failed to behave as a worthy person, as one conceives a worthy person behaves. Shame involves our conception of honor, worth and moral status. The worth of a nurse is inextricably linked to his or her behavior as an advocate for the vulnerable. The nurse may feel shame in failing to behave as a hero when heroics would be required to appropriately advocate for a patient.

In distinguishing between guilt and shame, Rawls' wrote:

> Imagine for example someone who cheats or gives in to cowardice and then feeling guilty and ashamed. He feels guilty because he has acted contrary to his sense of right and justice. By wrongly advancing his interests he has transgressed the right of others...yet he also feels ashamed because his conduct shows that he has failed to achieve the good of self-command, and he has been found unworthy of his associates upon whom he depends to confirm his sense of his own worth. (Rawls 1971, p. 339)

In the case of nursing actions that involve a violation of the nurse's moral obligation to the patient (advocacy), guilt and shame may both come to play in the emotions of the nurse.

THE NATURE OF EMOTIONS

Questions about the nature of emotions confront psychologists and philosophers and no commonly accepted answers prevail. Rather, there is a fairly wide divergence of predictions about what eventual answers will reveal. In the past decade, questions about the role of emotions in moral judgment and behavior have attracted a fair amount of attention with multiple disciplines working on similar questions (Davidson 1994).

Emotions were once viewed as too unreliable, seductive or frivolous for serious ethical considerations. This argument held that emotions are distracting to moral judgment and have nothing to do with cognition. This weak conception of emotions is now largely dismissed within philosophy and moral psychology. It seems clear that emotions are closely linked to beliefs, unlike bodily sensations. For example, grief is nothing like being thirsty. Thirst is not dependent upon a belief. Grief involves a belief that something or someone of value has been lost. A change in a belief will change or eliminate the emotion.

Another objection about the importance of emotions in moral considerations argues that while emotions have much to do with cognition, they embody a view of the world that is false. Traditional moral theory has stressed the need to separate from our emotions in order to make sound moral judgements. Philosophy has tended to claim that emotions are not a part of the equipment one needs to discern moral answers since they are intrusive and apt to cloud our judgement with bias. Ethics has focused on duties, obligations, prohibitions and perhaps motivations and intentions - but not on what a given

moral agent ought to be feeling. Emotion has been suspect as a basis for moral action. Anger and guilt might provoke or incite us, rather than move us by way of reason.

Kantianism and Utilitarianism are equally suspicious of emotions. The traditional Kantian views emotion as a problem for individual happiness, but not for morality. For contemporary Kantians, emotions are meaningful to duty, but duty remains the only morally worthy motive.

Utilitarians believe emotions deter rationality, hindering an impartial perspective. Within a utilitarian view, emotions are handled in terms of a rational calculation. Emotions must submit to a rational evaluation before utilitarian calculations can begin. In this search for algorithmic moral wisdom and judgement, only cool, calm reflective impartiality is capable of delivering considered moral judgments.

> Like the Kantian approach, the Utilitarian approach relies on abstract general principles or rules to be applied to particular cases. And it holds that although emotion is, in fact, the source of our desires for certain objectives, the task of morality should be to instruct us on how to pursue those objectives most rationally. Emotional attitudes toward moral issues themselves interfere with rationality and should be disregarded. (Held 1993, p. 50)

The Aristotelian, Martha Nussbaum (1990, p. 153), has argued that the pursuit of moral wisdom **without** emotion can prevent the achievement of adequate practical wisdom:

> ...(the truly good person) will not only act well but also feel the appropriate emotions about what he or she chooses. Not only correct motivation and motivational feelings but also correct reactive or responsive feelings are constitutive of this person's virtue or goodness. If I do the just thing from the wrong motives or desires (not for its own sake but, say, for the sake of gain), that will not count as virtuous actions.

The role of emotion in moral wisdom is, in this view, essential.

Nussbaum's thoughts on emotions and virtue help explain nurses' shame and guilt. A part of virtue involves having harmony between one's actions and one's feelings about the actions. Nurses are experiencing moral distress, in part, because their actions and their feelings about their actions are inconsistent and disharmonious. Their integrity is compromised by the crisis between what they do and what they believe to be the right thing to do. A nurse's realization that his or her actions do not promote the good of the patient contributes to feelings of guilt and/or shame. In reading the narratives of nurses, one can distinguish a sense that actions are in conflict with feelings about the rightness or correctness of the actions. Furthermore, one can sense the loss of self-esteem, i.e. shame, if the nurse fails to live up to his or her professional ideals.

Nurses, by virtue of the nature of their clinical tasks, will, theoretically, feel "bad" about certain aspects of their work – such as inflicting pain during an injection. However, there is no guilt or shame involved in that action. The nurse feels empathetic to the patient's pain, but believes the injection is a means to a worthy end. Feelings of guilt or shame associated with moral distress in nursing refer to the unpleasant incongruence between what the nurse does and what she believes is the appropriate means to a worthy end.

Having defined the nature of guilt and discussed the relationship between emotions and moral considerations, I will now turn to the expressions of guilty feelings in the stories of nursing experiences. I will show that guilt is a more significant factor in the moral distress of nurses than has been suggested by others.

WHY LOOK AT NURSES' POETRY AND STORIES?

In the poetry and stories of and about nursing, one rarely finds an explicit description of guilt feelings. Rather, guilt is alluded to indirectly. In nursing literature, guilt is glimpsed. It maintains a peripheral yet distinct presence. I have chosen to examine the presence of guilt in the stories some nurses have told about nursing. These true stories, told by real nurses, are understood to be paradigmatic stories of the nursing experience. They are the authentic, candid voices of a few of America's nurses. The goal of these narratives is to provide the reader with a snapshot of what nurses face in their daily work. They are the stories nurses feel compelled to tell.

While narratives of this type allow the writer the opportunity to present their experience with a particular audience in mind, I believe the theme of guilt is present. Feelings of guilt or shame are subjective. The narrative examples I have included are called from a small body of subjective resources available to examine moral distress. It is significant that guilt is so frequently, if implicitly, present in these narratives.

POEMS BY NURSES

In writing poetry, we choose to describe things closer to our heart. Poetry is often chosen as a form of expression when there is no other way to express what we feel. When other forms of description seem inadequate, we turn to poetry. Poetry, more than other forms of writing, is used when we want to evoke emotions. This makes poetry compatible with the need to express feelings of guilt or shame.

All of the narratives I have selected are written by real nurses and selected because they give an account of the emotions of nurses and the mechanism of those emotions. They are all works published in the 1990's, as compared to the analytical literature about moral distress, mostly published in the 1970's and 1980's. I believe the literary selections I have chosen represent a larger body of material which reiterates identical themes of moral distress.

In the poetry of Cortney Davis (1997), a practicing nurse, there is the subtle expression of guilt. In the poem, *Suffering* (Davis 1997, p. 15), Davis describes the nurses' "nightmare:"

> Waking, I realize it isn't death I fear
> But that half-death, suffering,
> So I can barely speak
> Of the patients kept alive:
> The eighty-five-year-old farmer, ribs cracked,
> All of them, to get his heart going,
> Or the burned woman whose arteries
> We pierced through the crust of her skin.

In describing the "half-death, suffering" of patients kept alive, Davis is referring to the performance of chest compressions, done during CPR (cardiopulmonary resuscitation) and the resulting rib fractures. In performing CPR, the chest must be compressed about two inches in order for the sternum to press against the heart, simulating contractions that force blood through the heart. The act of compressing the chest of an elderly human nearly always involves rib fractures as the porous quality of the older skeleton gives way to the pressure required to compress the sternum two inches. For the reader who has not had the misfortune of experiencing a rib fracture, it is exquisitely painful. Even the fracture of one rib causes enormous pain that repeats with each and every breath. The

sound of ribs fracturing is both audible during CPR and can be felt as a crunching sensation with each sternal compression. Every nurse who has either received CPR training (essentially 100% of U.S. nurses) or participated in a resuscitation (a likely event in the routine career of a hospital nurse) has felt that crunch or heard it.

Davis' other example of a patient "kept alive" is a burn patient. The actual care of burn patients generally involves only a small percentage of nurses: those employed in burn centers, emergency rooms or trauma centers. Still, nurses are largely aware of the devastation caused by a major burn. Davis' description of the "crust" of the burned woman's skin is seen in more severe burns. Burns involving all the layers of the skin and some muscle or bone are termed "full thickness," or third or fourth degree burns. These burns leave "skin" charred and often blackened into a dry, leathery or crusty appearance. Davis describes the placement of IV's or arterial monitoring devices which, in the case of burned patients, must frequently be inserted through the charred skin into vessels underlying the burn wounds.

What is not said but rather "hangs in the air" of Davis' poem is the nurse's responsibility in participating in something she believes to be morally unwise. Davis chooses these two particular patients to unmistakably illustrate the futility of many resuscitation efforts.

Davis wishes to describe explicit actions that now haunt her in her dreams. The poem expresses a sense of terror of being "kept alive," an experience she perceives as more frightening than death. Horrified about her own participation in the infliction of pain and suffering on patients – she describes herself as breathless, unable to speak of it. Rather, it troubles her sleep. She imagines the pain and suffering she has participated in.

She may even wonder that she would "deserve" the punishment of being "kept alive" as her debt for participating when rebellion would have been in order. There is no sense of the nurse being "compelled" or "overpowered" to participate in the events she describes. There is a sense of horror, shame and guilt about the "the patients kept alive," and the nurse's inability to atone for her actions. She cannot reconcile the hurt she has inflicted on others with its ultimate purpose.

In Cortney Davis' collection of poetry and prose by other nurses (1995, p.203), Belle Waring offers a poem about nursing in a Neonatal ICU:

> tries a nose-dive, kamikaze,
> when the intern flings open the isolette.
>
> The kid almost hits the floor. I can see the headlines:
> DOC DUMPS TOT. Nice save, nurse.
>
> Why thanks. Young physician: "We have to change
> The tube." His voice trembles, six weeks
>
> out of school. I tell him: "Keep it to a handshake,
> you'll be OK." Our team resuscitated
>
> this Baby Random, birthweight
> one pound, eyelids still fused. Mother's
>
> a junkie with HIV. Never named him.
> Where I work we bring back terminal preemies,
>
> No Fetus Can Beat Us. That's our motto. I have
> a friend who was thrown into prison. Where do birds
>
> go when they die? Neruda wanted to know. Crows
> eat them. Bird heaven? Imagine the racket.
>
> When Random cries, petite fish on shore, nothing
> squeaks past the tube down his pipe. His ventilator's
>
> a high-tech bellows that kicks in & out. Not
> up to the nurses. Quiet: a pigeon's outside,

color of graham crackers, throat oil on a wet street,
wings spattered white, perched out of the rain,

I have friends who were thrown in prison, Latin
American. Tortured. Exiled. Some people have

courage. Some people have heart. Corazon.
After a shift like tonight, I have the usual

bad dreams. Some days I avoid my reflection in store
windows. I just don't want anyone to look at me.

Waring's poem is, in many ways, an expression of cynicism in nursing. The nurses have named the baby "Random." A one pound neonate, born of an HIV-infected drug addict has a poor chance of survival and virtually no chance of surviving without some devastating, lifelong disability (Duff and Campbell 1997, p. 60-61). In this poem, random could be defined as "haphazard," since this is how such events might come to be perceived. The baby represents the large number of unplanned, unwanted babies born with overwhelming medical, social, financial and emotional obstacles. Of the babies that survive this sort of start in life, most will die well before reaching adulthood, following repeated hospitalizations. The baby feels "random" to the nurse, like a senseless tragedy.

The nurse describes a way of coping with the suffering involved in witnessing and participating in the calamity of neonatology. They use dark, morbid humor: "no fetus can beat us." And, they use distancing: "Keep it to a handshake." These are two ways of coping with conflicting moral issues that are paradigmatic in hospital nursing (Chambliss 1997; Kraegel and Kachoyeanos 1989; Heron 1998). Emergency departments and ICU's are notable for a milieu that includes "sick" jokes. Concerted efforts are made to "remove" oneself emotionally, in order to remain "objective" and "professional."

This nurse, like Davis, is not explicit in her expressions of guilt, but it is invoked throughout the poem. "Where I work we bring back terminal preemies." This line of the poem seems to express the nurse's sense of futility and senselessness about her work. It is expressed in a way that acknowledges the paradox of a career spent in efforts to "save" those who are terminal from the start.

The nurse uses poetic comparisons about courage. Corazon is the Spanish word for "heart." The baby is terminal and presumably "weak of heart." "I have friends who were thrown in prison...tortured...exiled.... After a shift like tonight, I have the usual bad dreams." She feels ashamed of being a coward, ashamed of not risking enough in order to behave in a way she believes a nurse is obligated to behave. The neonates are innocents, not unlike other innocents who've been put in prisons.

The tone of the poem is set in the beginning as the speaker describes the baby as a kamikaze. The baby is destined to die as if on a suicide mission. There is no pretense that the baby can survive – throughout the poem, the death of the baby is inevitable. The nurses' action (catching the baby that nearly hits the floor when the young doctor rather carelessly flings open the isolette) mimics her condition as nurse in the NICU. She is "caught" in a situation she feels is inescapable.

Finally, the nurse tells the reader of the extent to which she is troubled by her work: "...bad dreams. Some days I avoid my reflection in store windows. I just don't want anyone to look at me." Like Davis' poem, there is a sense of being haunted, of "losing sleep" over her actions. The shame is implicit in the phrase, "I just don't want anyone to look at me." Shame connects with sight – with how we look at ourselves and how others look upon us. Shame is present in the desire to hide, to vanish, and to be

unable to stand the sight of oneself. Guilt connects with hearing and the "voice of conscience" speaks in this poem. The poem is, essentially, a "confession" the nurse feels compelled to make (Morris 1971, p. 62).

Implicit in the actions of the nurse is autonomy, distinct and separate from that of the doctors. Her tone is that of one caught in a futile effort. Unlike moral distress resulting when one is constrained by others, this is the voice of one who feels guilt and shame in behaving as a coward. The nurse is experiencing a loss of integrity and perhaps, some of her humanity.

STORIES NURSES TELL

Nurse narratives abound in which nurses discuss their experiences of having their moral decisions "trumped" by more powerful "others" (including physicians, hospital/nursing administrators, and the law). In the following narrative, a nurse describes her conflict with a hospital administrator:

> ...There was one incident involving a little girl from a rural area. She'd had severe headaches off and on over a period of time. When she was on the CT scan table, she arrested. They resuscitated her but the scan revealed a very large blastoma (malignant brain tumor). So, here was this little girl – eight years old, beautiful, with dark hair and dark eyes – with a subnormal body temperature of 86 degrees....
>
> I was comfortable with my assessment but I was having a very difficult time dealing with people dying, especially young people. I was only 21 or 22 myself. This little girl's family was a very close kin network. People were literally coming in droves with their aprons and work clothes still on to visit her and to be with the family. I was just letting people come in to see this girl whenever they wanted to.
>
> The nursing supervisor, an older, rule-oriented nurse, approached me and said, 'Don't you realize that visitation privileges are for immediate family only?' ...She went on to say that she was tired of stumbling over visitors in the hall and why was I so intent on trying to include the family?

> That really bothered me because I had to start limiting who could visit....
> (Rittman and Nedoma et al 1993, p. 40-41)

This narrative highlights one type of moral conflict between nurses and administrators in health care. While the hospital administrator is also a nurse, her role is one of maintaining an orderly or "manageable" environment in the hospital ICU. But is this nurse powerless to the dictates of the administrator? This 1993 narrative, taken from a widely read nursing journal, goes on:

> ...At the door I would ask if they were family and, if not, say they couldn't come in. The look on their faces when I told them they couldn't visit was horrible.
>
> From that time on, I decided that I would never care for a patient in isolation from family or friends. I always extend my care of ICU patients to the network of relatives or friends. Sometimes it's hard to do in an ICU but it's very important to me.

The nurse is both describing her own sense of guilt involved in her actions taken at the "orders" of the administrator and the action that guilt ultimately motivated. In the nurse's assessment, the family and extended family needed to be with the child. Initially the nurse's response to the administrator was compliance; however, the nurse thought better of this and took a more heroic action in future situations. The nurse had moral agency which she chose to exercise following the guilt and shame she experienced as a result of her part in breaching the relationship with the family.

Many nursing narratives make an analogy between the pain/suffering of the patient and that of the nurse. Guilt springs from seeing the patient's suffering, but nurses understand the nature of the actions they take and identify with the position of the patient or family. What they do to others, they imagine doing to themselves. The guilt of the

nurse is grounded in her own actions or inactions, not just the constraining action of the "other."

In 1993, the ICU nurse making decisions about patient visitation had a greater sense of autonomy than in decades past. The above story involves a reflection of an event from earlier in the nurse's career, when, as a young nurse, she was less inclined to question the dictates of a hospital administrator. This story reflects the complex evolution of a nurse's moral decisionmaking skills and undoubtedly a change in culture reflecting social/political changes such as the civil rights movement, labor movement and the women's liberation movement.

Today's nurses have begun to exert pressure on hospitals to reexamine the value of the nurses' care. Philosophers, educators, feminists, sociologists and an assortment of others have debated the nature and significance of caring. Caring involves not only what you do but also who you are. Throughout history, caring has always been linked to womanhood, to femininity. The hospital, as an institution in which medical treatment and nursing care are provided, is about a hundred years old. Prior to this, medical care was provided mainly in the home and women were expected to "nurse" the ill. This gender-based "duty to care" and its implications for the nursing profession are chronicled in Susan M. Reverby's *Ordered to Care: The Dilemma of American Nursing 1850 to 1945*. As Reverby spells out in her history of nursing, one cannot understand the dilemma and distress of nursing without considering the history of women and labor.

A specific type of story has evolved in nursing literature creating a whole genre of "nurse as moral hero" narratives. These accounts of nurses' moral struggle within the American health system correlate to the struggle of women in American culture and, in

particular, the struggle of women as consumers of health care. Nurses have criticized physicians and health care systems for being condescending and paternalistic toward nurses, patients and female patients, in particular. Nurses moral distress is largely reflective of the same experience of dismissal, of being disbelieved and of discontent that characterizes the reports of women's experience with health care in America (Apple 1990). The development of the nursing profession has paralleled the relationship of women to men. Today's practicing hospital nurses are expected to think and act for themselves and no longer function under the assumption that doctors have the only role to play in health-care decisionmaking. Today's nurse is expected to act as an autonomous moral agent, not a subservient handmaiden and order taker.

In Helga Kuhse's *Caring: Nurses, Women and Ethics* (1997), the following story from the nursing journal, *Nursing Life*, is reprinted. The 1992 publication by a U.S. nurse is her autobiographical story of ignoring medical orders and the law in order to allow her patient to die:

> ...Mac was a young, witty, macho cop who walked into the hospital with 32 pounds of attack equipment, looking as if he could single-handedly protect the whole city, if not the entire state. 'Can't get rid of this cough,' he said. Otherwise, he felt great.
>
> Before the day was over, tests confirmed that he had lung cancer. And before the year was over, I loved him, his wife Maura, and their three kids as if they were my own family. All the nurses loved him. And we all battled his disease for six months without ever giving death a second thought. Six months isn't such a long time in the whole scheme of things, but it was long enough to see him lose his youth, his wit, his macho, his hair, his bowel and bladder control, his sense of taste and smell, and his ability to do the slightest thing for himself. It was also long enough to watch Maura's transformation from a young woman into an old lady.
>
> When Mac had wasted away to a 60-pound skeleton kept alive by liquid food we poured down a tube, I.V. solutions we dripped into his veins, and oxygen we piped to a mask on his face, he begged us: 'Mercy. . . For God's sake, please just let me die.'

> ...Each time he stopped breathing, sometimes two or three times a day, the code team came again. The doctors and technicians worked their miracles and walked away. The nurses stayed to wipe the saliva that drooled from his mouth, irrigate the big craters of bedsores that covered his hips, suction the lung fluids that threaten to drown him, clean the feces that burned his skin like lye, pour the liquid food down the tube attached to his stomach, put pillows between his knees to ease the bone-to-bone pain, turn him every hour to keep the bedsores from getting worse, and change his gown and linen every two hours to keep him from being soaked in perspiration.
>
> ...Every morning I asked his doctor for a 'no code' order. Without that order, we had to resuscitate every patient who stopped breathing. His doctor was one of several who believed we must extend life as long as we have the means and knowledge to do it. To not do it is to be liable for negligence....
>
> And after the 52nd code, when Mac was still lucid enough to beg for death again, and Maura was crumpled in my arms again, and when no amount of pain medication stilled his moaning and agony, I wondered about a spiritual judge.

In this part of the story, the stage is set. The nurse has a relationship with the patient and family formed over the course of several months as Mac deteriorates from a strong, healthy, powerful individual into a bedridden, emaciated, dying skeleton. The description of caring for Mac is painful to read. One can almost feel the humiliation of incontinence, the pain of skin sores and the ache of "bone-to-bone" pressure. The nurse identifies with the suffering of Mac. The emotional pain of watching someone deteriorate parallels the physical pain Mac endures.

The position of the doctor as insisting on continuing to resuscitate Mac is described in a "black or white" way that seems morally ludicrous and cruel. The doctor's participation in Mac's health care is from a position distinctly more removed from the patient than that of the nurse. The nurse is intimately experiencing the display of Mac's painful and humiliating deterioration. The nurse's moral suffering about "allowing" or even "participating" in this pretense is further described:

> At night I went home and tried to scrub away the smell of decaying flesh that seemed woven into the fabric of my uniform. It was in my hair, the upholstery of my car – there was no washing it away.... I thought about what it would be like to stand before a judge, accused of murder, if Mac stopped breathing and I didn't call a code.... Such questions haunted me more than ever early one morning when Maura went home to change her clothes and I was bathing Mac. He had been still for so long, I thought he at last had the blessed relief of coma. Then he opened his eyes and moaned, 'Pain...no more...Barbara...do something...God... let me go.' The desperation in his eyes and voice riddled me with guilt.

Unlike examples I will offer later, this narrative explicitly identifies guilt as a part of the nurse's experience. The nurse knows Mac is terminally ill and suffering. She is very aware of the law forbidding euthanasia or assisted suicide and the authority of the doctor's decisions in this context. Still, she "knows" that resuscitating Mac is "wrong," and as a nurse, she is obligated to the promotion for and protection of the patient. She is afraid of the legal consequences of not "calling a code" and haunted by her sense of moral responsibility to the patient. She makes the decision of a "hero:"

> I sat on the bed and held Mac's hands in mine. He pressed his bony fingers against my hand and muttered, 'thanks'. Then there was a soft sigh and I felt his hands go cold in mine. 'Mac' I whispered, as I waited for his chest to rise and fall again.
>
> A clutch of panic banded my chest, drew my fingers to the code button, urged me to do something, anything...but sit there alone with death. I kept one finger on the button, without pressing it, as a waxen pallor slowly transformed his face from person to empty shell. Nothing I have ever done in my 47 years has taken so much effort as it took not to press that code button.
>
> Eventually, when I was as sure as I could be that the code team would fail to bring him back, I entered the legal twilight zone and pushed the button. The team tried. And while they were trying, Maura walked into the room and shrieked, 'No...don't let them do this to him...for God's sake...please, no more.'
>
> Cradling her in my arms was like cradling myself, Mac and all those patients and nurses who had been in this place before who do the best they can in a death-denying society.

In the average U.S. hospital today, decisions to "code" or not to "code" patients are not so unilaterally ascribed to the doctor. Our society assumes the patient and/or the family should have a voice in such decisions. Nurses often discuss the benefits and burdens of resuscitation with patients and families. Yet, stories of hopelessly ill patients subjected to painful, undignified, futile resuscitation attempts persist.

For most readers of this story, the nurse is a courageous hero. Defying the law, risking social ostracism and job loss, the nurse takes a stand on behalf of a hopelessly ill and suffering human being. Using graphic descriptions of the patient's appalling physical condition, the reader sympathizes with the torment of the nurse. In today's social/political climate in the U.S., her daring action is applauded as that of champion and martyr.

Like the other narratives, the nurse personalizes what was done to the patient and family. In cradling Mac's wife, she cradles herself and other nurses who have felt the way she feels. The anguish the nurse feels is mirrored to the agony of the patient and family.

Suzanne Gordon's (1997) *Life Support: Three Nurses on the Front Line* sets out to describe how nurses are positioned in health care and how that positioning contributes to nursing's "moral distress." Like others who have described moral distress in nursing, Gordon frequently places nurses in the position of the powerless female. In a story about a dying patient in pain (p. 238-240), a nurse tries to convince the intern, resident and attending physician that a patient is in terrible pain. The attending physician and consequently, the resident and intern in his charge, is fearful of providing adequate pain relief that could decrease the patient's respiratory rate and blood pressure. This fear is

largely a matter of ignorance about the use of narcotics, but also centers on a phenomena sometimes observed among physicians - fear of litigation as the basis of medical treatment decisions. Nearly every medical or nursing ethics text has such a story of a physician making morally indefensible treatment decisions, often creating clever and elaborate "justifications" like the one described in Gordon's book, in an effort to place himself out of "harm's way" in terms of liability (Rodwin 1993).

While Gordon goes on to tell how the nurses endeavor to improve the quality of care for the dying (by attempting to implement a palliative care service at the hospital), she fails to share more convincing specifics about how the "hierarchical structure" prevents the nurse from intervening on this patients' behalf. The nurse(s) are presented here as helpless, powerless victims of an organization that tolerates sadistic medical practices. The questions Gordon does not address include: what is the nurse's moral and legal obligation to the type of patient in this story? What institutional structures exist that might support the nurse in advocating for this patient? What do nurses really feel in a situation like this? The nurse in this story describes feeling "terrible" about not being allowed to help the patient and describes the "hierarchical structure" as one that "deprives patients of caregivers with wisdom and experience." Is this accurate in today's hospital? Are today's hospitals structured without input from nurses? Are nurses morally and practically "bound and gagged" in the current U.S. hospital system? Are patients being deprived of care by wise and experienced caregivers? If the attending physician, the most experienced of the three physicians involved in this case, is making unwise and potentially harmful decisions - who is next in the hospital medical hierarchy? Gordon's story leaves these questions dangling and the reader should ask: why?

The nurse in Gordon's story failed to convince the attending physician to properly medicate the painful, terminally ill patient. The nurse maintains she had no options in the case except to allow the patient to die two weeks later with no effective pain management. She felt "terrible" about it. The story has an empty, inauthentic ring to it.

This example of a nurse's "moral distress" in dealing with more powerful players in the health care environment fails to identify any serious moral lapse on the part of the nurse. This tendency to ignore the moral responsibility of nurses may stem from the myth of the nurse as "angel of mercy." While Gordon's story implicates physicians and "hospital hierarchy," it does not absolve the nurses; nor does it convince the reader of nurse victimization.

NURSE METAPHORS

Nurses have long "enjoyed" the reputation as one of the most virtuous professions in the world. Nursing is defined by the act of caring by one human for another, reinforced by social conditions and historical context in which women are subservient, even eager subordinates. This understanding of women as being endowed by God and nature to be caretaker and mother is the epitome of the turn of the century nurse in the U.S. (Reverby 1993). Not until the feminist movement of the 1960's and 1970's was the ethics of subservience to medicine removed from nursing education. Prior to this, part of the ethics and education of nurses involved instilling a sense of servility and subordination to medicine.

In spite of this historical vision of nursing's obedience to doctors, nurses since Florence Nightingale have been expected to practice "*intelligent* obedience" (Kuhse 1997, p. 32). Nurses are not today, and never have been, expected to obey doctors making mistakes. The American Nurse Association's *Code of Ethics for Nursing* (1998) clearly states:

> The nurse's primary commitment is to the health, well being, and safety of the patient across the life span and in all settings in which health care needs are addressed. This includes not only those acts that prevent, promote, maintain, and restore health but also those that alleviate suffering and promote a peaceful, comfortable and dignified death. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical or illegal practice by any member of the health care team or the health care system, or any action on the part of others that places the rights or best interests of the patient in jeopardy.

Today's practicing nurses clearly perceive their primary responsibility to be toward patients rather than to doctors. Nurses in today's U.S. hospital strive for a cooperative collaboration with doctors and other healthcare team members in advocating for patients. Subservience or blind submission to doctors is strongly discouraged and would by no means serve to defend a nursing error or dereliction of accepted practice. Today's nurse must be able to distinguish practice standards for patients and is mandated to act when those standards are violated.

It is today's expectations of nurses that give rise to the voice of guilt. Nurses today know they are, in every sense of the definition, obligated to act against a doctor who would persist in contributing to the needless suffering of a patient, or the institution where practices threaten the welfare of patients. It may, however, be the persistence of the cultural metaphor of nurse as saint/mother/disenfranchised woman that blinds researchers to guilt and shame in the experience of some nurses.

UNDERSTANDING MORAL DISTRESS IN NURSING

Why is it useful to understand moral distress in nursing? There are many reasons but two seem to overshadow the others. First, the shortage of nurses in the U.S. in 1999 is estimated to be 300,000. Projections indicate the shortage will double by the year 2005. By the year 2015, with the full retirement of baby boomers, the nursing shortage is expected to reach 1.6 million nationally (Curtin 1999). Secondly, associate degree nursing programs are closing at alarming rates as enrollment drops to unprecedented lows. Nurses are becoming and will continue to be a precious commodity. Will more money keep them or recruit new ones? Hospitals across the country currently scramble to study and learn the keys to nursing retention as the numbers of open positions grow and persist. While financial reimbursement is always a consideration and probably a valid one for nurses, most experts are convinced that money is a secondary issue (Malloch, Everett, Watson 1999).

Are nurses leaving the nursing profession because they feel overwhelming moral distress? It is an issue that is beginning to demand consideration. Corley's 1995 study of moral distress in critical care nurses showed 12% reporting leaving nursing due to issues of moral distress (p. 280). Initiated by informal, though numerous, complaints by nurses of moral compromise in their daily work, the institutional ethics committee of a large Midwest health system assigned a task force to study the problem in 1998. Focus groups conducted by outside agents utilizing strict confidentiality indicated widespread feelings of frustration, anger and cynicism.

The 1999 state-level meeting of the American Nurse Association in Michigan (the Michigan Nurse Association) featured a full day of discussion by nurse-ethicist Leah Curtin on the topic, "Moral Distress Among Nurses: A National Malaise." Her advice to nurse complaints about moral compromise in acute care (hospital) nursing practice, "mandatory" overtime policies, and unsafe nurse-patient ratios was simple: try to work with the institution to examine nursing's autonomy to practice nursing as nurses believe it must be practiced. Elicit the support of your professional organizations. Failing these efforts – QUIT! Take a job somewhere else.

These are just the first rumblings of what has the potential to become a nationwide quake of nursing dissatisfaction that has the potential to rock the health care industry. Kuhse (1997, p. 199) calls nursing the "the slumbering giant," an appropriate metaphor. If, or when, nurses decide to exercise the enormous power they possess, the health care industry could be brought to its knees.

Assuming moral distress is a significant factor in the experience of nurses in the U.S., why is it important that we understand guilt as a component of that distress? It would enormously alter how we address the problem. If it is true, as I assert, that a significant component of moral distress for nurses is grounded in feelings of guilt about unused moral agency, more complex answers will be required. If it is true that nurses have moral authority but fail to exercise it, this will demand an examination of "why?" Why do nurses so often find themselves lacking the freedom to honor their commitment to patients?

Moral distress such as is revealed in these narrative selections is not subject to a "quick fix," like the wage increases that addressed the nursing shortage in the 1980's

(Watson 1999). It is not a matter of treating the individual psyche, but rather a problem of process within the institutions of healthcare. Offering support to individual nurses troubled by moral issues probably won't be effective. A great majority of U.S. hospitals have existing ethics committees accessible to nurses. Many have developed nursing ethics committees devoted to moral issues in nursing. Over 90% of hospitals have policies and procedures regarding resuscitation, informed consent, and treatment withdrawal. However, the impact of these policies on actual practice is questionable.

What conditions within healthcare institutions contribute to the moral conflicts experienced by nurses? What constitutes an ethical work environment for nurses and how essential is it for nurse retention? Is there a shared moral language and mutual respect among physicians and nurses? What are the perceived and actual constraints on ethical nursing practice? What must be present within nursing practice environments to prevent those nurses most sensitive to moral issues from leaving the profession? What practice changes are required to ensure appropriate coping strategies for those nurses who feel resolute about patient advocacy and accountable for their own actions? These questions point to the need for further research into moral distress in nursing practice.

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