

**MORAL DISTRESS IN A NON-ACUTE CONTINUING CARE SETTING:
THE EXPERIENCE OF REGISTERED NURSES**

by

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Abstract

The moral distress experiences of Registered Nurses who work in non-acute, continuing care settings were examined using qualitative methods. Previous research suggests that in general, nurses experience moral distress when they are not able to pursue actions in accordance with their moral conscience. Moral distress in nurses is expressed negatively in both the nurses' professional and personal lives. However, most research on moral distress among nurses has focused on acute care settings.

Registered Nurse participants were recruited from non-acute continuing care settings and described their experiences of moral conflict and distress. Particular attention was placed on the nurses' experiences and reactions to their experience. The findings from this study indicated that as in other settings, moral distress is present in Registered Nurses practicing in non-acute continuing care. The nurses' practicing in non-acute continuing care settings experienced moral distress after facing a barrier to their moral conscience involving organizational functioning, end of life decisions, patient advocacy, and resource utilization. Nurses experienced feelings including powerlessness, concern, regret, disappointment, suspicion of others, and feeling devalued. Future studies may focus further on the subspecialties in the non-acute continuing care sector. Research on strategies to resolve moral distress and research on the effectiveness of current interventions to combat moral distress among Registered Nurses in this setting should be pursued.

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Chapter 1

Introduction

After major health care cut backs, reduced available resources, and nurse layoffs in the 1990s, nurses often faced situations in which they could not fulfill their moral commitments which led to ethical conflict between the nurse and the organization. In a health care environment that continues to face rapid scientific advancements, an aging population, patients living longer with complex medical conditions, and limited financial and physical resources, the complexity and frequency of ethical conflict and uncertainty among nurses continues to mount (Rodney & Starzomski, 1994; Lamb, 2004).

Moral distress is “psychological disequilibrium” as well as associated negative feelings experienced as a consequence of an individual failing to act on their personal conscience and moral decisions (Wilkinson, 1987/1988). Failure to carry through with the appropriate action can be related to institutional obstacles such as lack of time, lack of organizational support, and legal constraints (Corley, 2002). Those care providers who are unable to cope with feelings of moral distress develop personal and professional problems. Those with moral distress describe personal effects of feeling worthless, angry, frustrated, depressed, ashamed, sad, and even miserable (Wilkinson, 1987/1988). The feelings related to moral distress also invade their home lives because they “couldn’t turn off” the negative feelings. Some described uncontrollable crying, nightmares, and even physical symptoms of heart palpitations and headache (Wilkinson, 1987/1988). Moral distress has also been attributed to a dispirited professional life; feelings of job dissatisfaction and “burnout”. Some nurses have attributed moral distress to their decision to leave the profession (Corley, 2002).

The phenomenon of moral distress has been widely explored in various clinical settings in which nurses practice. Current literature includes practice settings such as acute care (Raines, 2000; Corley, Minick, Elswick, Jacobs, 2005; Oberle, Hughes, 2001; Kalvemark, Hoglund, Hansson, Westerholm, Arnetz, 2004; Rager Zuzelo, 2007), adult and neonatal critical care (Rager Zuzelo, 2007; Hefferman, Heilig, 1999; Gutierrez, 2005; Sundin-Huard, Fahy, 1999; Elpern, Covert, Kleinpell, 2005) and acute and community psychiatry (Sturm, 2007; Austin, Bergum, Goldberg, 2003; Austin, Rankel, Kagan, Bergum, Lernermeier, 2005). After an extensive literature review, there was little research identified that focused on moral distress among nurses in continuing care settings.

Continuing care settings refer to health care environments that provide 24-hour nursing care to patients who may have chronic illness, be close to the end stage of their disease process and who often have multiple health care needs. These patients have an established diagnosis but require ongoing care, evaluation, and treatment. Although their acute medical condition has stabilized, they still may require technical assistance and close monitoring.

Problem Statement

When the nurse's moral choices and actions are thwarted by external constraints, feelings of anger, frustration, guilt, and powerlessness develop in the nurse's personal and professional life. These feelings are often termed 'moral distress' (Rodney, Brown, Liaschenko, 2004). There has been literature describing the concept of moral distress and investigation of moral distress in acute care and critical care nursing, but there has been little examination of moral distress in non-acute areas of nursing practice and little is known about the experiences of nurses in these settings.

Perspective of the Researcher

The majority of my clinical nursing experience is in critical care. While working in a medical and surgical intensive care unit caring for adults and paediatric patients, I often experienced situations in which I witnessed and participated in painful invasive procedures and aggressive care for patients who I did not expect to survive or who were expected to have a low quality of life. I often felt that my personal moral values of patient dignity and easing suffering were in conflict with the treatment decisions. I believe that this prolonged sense of conflict led me to contemplate leaving the profession of nursing entirely and ultimately influenced my decision to leave my position as a clinical nurse.

After living and recalling my experiences of ethical dilemmas and subsequent moral conflict, I developed an interest in exploring the experiences of nurses in other clinical settings. After reviewing the literature I found very little research exploring moral dilemmas and conflict in non-acute care nursing. I decided that a qualitative exploration of moral distress of non-acute continuing care nursing would facilitate in determining if there were similarities or differences in the moral distress experiences of nurses practicing in this setting.

Purpose of the Study

The purpose of this study was to describe the experience of moral distress of Registered Nurses who work in non-acute continuing care settings.

In the next chapter there is a literature review of moral distress, and a conceptual model that was adapted from the literature. Chapter three outlines the research methods including the purpose, research questions, design, setting, participants, recruitment and ethics approvals.

Chapter four includes the findings from the research, which includes participant characteristics and emergent themes. In chapter five there is a discussion of the fit between the research findings and the available literature. The final chapter discusses the limitations of the study and the implications of the findings for future research, nursing education, practice and administration. The final chapter also includes a summary and conclusions of the study.

Chapter 2

Literature Review

In this literature review, I present a critical examination of theoretical and empirical research published in peer-reviewed journals on moral distress. A computer-aided search strategy using OVID search engine was conducted. The following databases were used: PsychInfo (from 1967 to January 2009), OVID Healthstar (from 1966 to January 2009), CINAHL (from 1982 to January 2009), and OVID Medline (from 1996 to January 2009). The following terms were used as key words to search the literature: moral deliberation, moral conscience, moral residue, moral agency, moral constraint, moral distress, nursing, ethics, ethical dilemmas, ethical conflict, ethical distress, and workplace distress.

Andrew Jameton (1984) first introduced the term “moral distress” in the early 1980’s, although the concept of moral distress is described in much earlier nursing literature. Since the introduction of the term moral distress there has been growing of consensus surrounding the concept of moral distress, including the causes, consequences and possible means of alleviation. The literature will be presented below with the intent to identify areas that have been addressed, gaps, and limitations.

Moral Distress

Holsclaw (1965) was one of the first researchers to investigate the concept of moral distress, although at the time the concept had not yet been articulated. Holsclaw described nurses who are at “high emotional risk” as a result of frequently being confronted by high morbidity and mortality of their patients. Holsclaw described three themes related to emotionally high-risk areas of nursing: (1) withdrawal, (2) anger, and (3) powerlessness. Holsclaw explained that one

of the most common ways for people to defend themselves against anxiety is to withdraw from the situation. Since nurses cannot often physically leave the situation, “unconscious withdrawal can be manifested instead by ignoring the patient as a person” (Holsclaw, 1965, p. 40).

When philosopher Andrew Jameton first introduced the concept of moral distress in 1984, he was exploring experiences of ethical dilemmas in nursing. Jameton initially described moral distress as “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984 p.6). Wilkinson (1987/1988) further developed and extended Jameton’s initial definition and described moral distress as:

The psychological disequilibrium and negative feeling state experienced when a person makes a moral decision, but does not follow through on performing the moral behaviour indicated by that decision (Wilkinson, 1987/1988 p. 16)

Wilkinson described the experience as consequences faced when an individual fails to act on their personal conscience. Wilkinson also introduced the concept of a “bifocal model” of moral distress. Bifocal moral distress is two modes of experiencing moral distress; moral distress can be experienced when a person makes a moral decision but does not act according to their moral conscience or it can be experienced as moral outrage. Moral outrage is when the nurse is not actually involved in the situation that produces the morally distressing event, but witnesses or indirectly experiences an event. Jameton (1993) later further refined his definition as follows:

In moral distress, a nurse knows the morally right course of action to take, but institutional structure and conflicts with other co-workers create obstacles. A nurse who fails to act in the face of obstacles also may have reactive in addition to the initial distress (p.542).

Jameton classified two forms of moral distress: initial and reactive distress. Initial distress is characterized by feelings of frustration, anger, and anxiety after an individual is faced with an obstacle or is in conflict with another person whose moral values differ. Reactive distress occurs when individuals do not act upon or resolve their feelings of initial distress (Jameton, 1993). The moral distress definition is different than that of moral uncertainty, in which the individual may not know which of multiple courses is the most appropriate or in which multiple courses are equally morally appropriate (Hamric, 2000).

Causes of Moral Distress

The sources of moral distress can stem from external factors such as limited resources and policy constraints or from experiences involving their patient's experiences of pain and suffering or lack of dignity (Corley, 2002). The nurses' inability to resolve these sources of distress and lack of control over their environment further contributes to their moral conflict (Omery, Henneman, Billet, Luna-Raines, Brown-Saltzman, 1995).

Peter and Liaschenko (2004) theorized that because nurses work at close proximity to their patients and carry out orders, this makes them more susceptible to the development of moral distress than some other care providers. Care providers who work at a greater distance from the patient experience a "moral protection" as it may be less distressing to give orders rather than carry them out, and witness the patient experiences first hand. Personal characteristics may also predispose some to experience moral distress more than others. While one study found no correlation between demographic characteristics such as education, age, and experience with level of moral distress (Corley, Minick, Elswick & Jacobs, 2005), another study by Kalvemark and colleagues (2006) investigating moral distress in all health care, identified younger health

care providers as having higher levels of moral distress. Although the sample in this study included pharmacists, pharmacy assistants, physicians, and auxiliary workers, nurses were by far the majority of the study's respondents. Hamric (2000) suggests that a possible explanation for the association between moral distress and youth and inexperience in nurses is that younger nurses have not yet developed moral competency--the ability to interpret moral situations, use good moral judgment, and engage in morally appropriate behavior. Moral agency is personally held values that provide motivation and enact a sense of responsibility capable of moral decisions (Rodney & Starzomski, 1993; Watson, Freeman & Parmar, 20007). Hamric suggests that an internal obstacle along with an inability to identify ethical issues, or a lack of alternatives also predisposes nurses to moral distress (Hamric, 2000).

As described in the following sections, the most commonly identified causes of moral distress in nurses include inadequate resources, providing medically futile care, disrespecting patient autonomy, relationships between physicians and nurses, and being unable to prevent death.

Inadequate Resources

Nurses often cite the external moral distress source of inadequate human or physical resources to meet the needs of their patients; this was overall the most intense and frequent cause of moral distress for nurses found while reviewing the literature. Nurses described a lack of time or staff being forced to prioritize their time between tasks that seem equally important. The nurses recognized that spending too much time with one patient means the others will have to wait or receive less care. The nurses' thought that the effects of staffing shortages included wondering if the care provided was adequate (Gunther & Thomas, 2006; Green & Jeffers, 2006;

Silen, Tang, Wadensten & Ahlstrom, 2008). Nurses were troubled when deaths occurred and the nurses were not available to be present due to time constraints. In a qualitative study by Austin, Bergum, and Goldberg (2003) the researchers found that the nurses thought that they were forced to deliver sub-optimal care in which the “patients’ pain and screams could not be attended”(p.180).

Nurses also found it difficult to call in sick to work because of the consequences if they did not come to work: patients were not seen; another colleague may have to do double the work without lunch or breaks or stay later (Kalvemarm, Hoglund, Hansson, Westerholm & Arnetz, 2004). Working with low staffing levels was morally distressing. Inadequate staffing to meet the needs of patient acuity made it difficult to meet the reasonable demands of patient care. Rager Zuzelo (2007) studied 97 Registered Nurses practicing in acute care using the Moral Distress Scale, which is a 7-point Likert scale to rate moral distress associated with clinical practice events and the frequency of the events occurring during practice. Items are scored from 0 to 6 with ‘0’ denoting no moral distress or never occurring in practice and ‘6’ indicating extreme distress or often occurring in practice. The results indicate that nurses thought that “unsafe” work levels happened infrequently (mean frequency=2.84; SD=1.88), but when the event did occur it was very distressing (mean score = 4.14; SD=1.93). The research findings reported only most frequently reported morally distressing events and statistical significance was not reported (Rager Zuzelo, 2007).

The amount of financial resources allocated for the provision of patient care and how resources were spent was often cited as causes of moral distress. Some health care providers thought that the administrative workload such as paper work, booking appointments and

inputting data was heavy and thought their focus ought to be on direct patient care. Nurses were not able to offer the care that they believed the patients are entitled to. Situations when there were more patients than beds available and staff were forced to choose between individuals who all need care, caused moral distress (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2007). In addition to the lacking of beds for patients, the lack of medical equipment and supplies that patients required was also a source of moral distress for nurses (Green & Jeffers, 2006).

Medically Futile Care

Medically futile procedures cause moral distress in the sense that the resources could have been spent elsewhere with greater effect, and that the aggressive care provided denied the patient of palliative care (Ferrell, 2006; Meltzer & Huckabay, 2004). Meltzer and Huckabay (2004) define futile care as:

Life sustaining interventions and treatment that have no medical benefit for a patient because the interventions and treatments cannot end dependence on intensive medical care (p. 203).

Nurses depending on the situation, their spiritual beliefs, their values, and years of experience interpret futility of care differently. The clinical situations focus on unnecessary treatments at the end of life and initiation of life- saving interventions that only prolong death (Rice, Rady, Hamrick, Verheijde & Pendergast, 2008). The misuse of resources by providing aggressive care including unnecessary procedures and treating the patient as an object was seen as a violation of the patient's dignity and an act of disrespect (Gutierrez, 2005; Corley, Elswick, Gorman, & Clor, 2001; Corley, Minick, Elswick, & Jacobs, 2005; McClendon & Buckner, 2007; Silen, Tang, Wadensten & Ahlstrom, 2008). Improper use of resources such as ordering

unnecessary tests, or situations in which extensive resources were spent on patients whose care was considered medically futile, or with poor quality of life outcomes was distressing. The perception of the nurses in these situations was that the distribution of often-scarce health care resources could have been more appropriately spent (Gutierrez, 2005; Corley, 2001; Ferrell, 2006).

In research conducted by Mobley, Rady, Verheijde, Patel and Larson (2007) and Rice, Rady, Hamrick, Verheijde and Pendergast (2008), a link was identified between age, cumulative years of nursing experience and the intensity and frequency of situations involving medically futile care. As age and years in nursing practice increased, the frequency and intensity of exposure to futile care increased ($p < 0.0001$) leading to moral distress manifested as emotional exhaustion and “burnout” (Rice, Rady, Hamrick, Verheijde & Pendergast 2008). There is also a significant relationship between educational preparation and moral distress when dealing with futile or inadequate care. In a study of 60 nurses working in a critical care setting the nurses prepared with a bachelor’s degree or higher experienced significantly more frequent feelings of moral distress. Using an analysis of variance with post hoc tests conducted on the Moral Distress Scale (MDS) as the dependant variable and education as the independent variable the results indicated nurses with bachelor’s degrees or higher had significantly higher scores ($F=4.27$, $P=0.009$) on the MDS (mean=154.19, SD 30.10) than nurses with an associate degree in nursing (mean= 126.58, SD 34.87) (Meltzer & Huckabay, 2004).

Disrespecting Patient Autonomy

Perceived disrespect of patient autonomy was also seen as a cause of moral distress. Barriers to patient autonomy included failing to tell the truth, such as when patients are not fully

informed of the situation, and failure to obtain informed consent (Rager Zuzelo, 2007).

Situations in which physicians disregarded patients' wishes were distressing to nurses; nurses who were assisting with or carrying out the procedure experienced moral distress in these situations. Some of these distressing situations included intubating or ventilating a patient despite a "do not intubate order" (Rager Zuzelo, 2007; Gutierrez, 2005; Corley, Elswick, Gorman, & Clor, 2001; Corley, Minick, Elswick, & Jacobs, 2005).

Relationships between Nurses and Physicians

Relationships between physicians and nurses have generated instances of moral distress. Some professional relationships between nurses and physicians were identified as ones of mutual respect, while other professional relationships involved physicians who disregarded the nurses when reporting their patient concerns and problems. Nurses described knowing what ought to be done for the patient, but not being able to convince the physician. Nurses felt ignored when trying to act in the best interest of the patient and the nurses experienced moral distress and feelings of powerlessness (Gunther & Thomas, 2006; Holly, 1993).

Some nurses have noted that the professional relationship between the nurse and physician was so strained that the nurse attempted to anticipate any possible retribution as a result of the nurse's actions. Often the nurses avoided situations of conflict with physicians; this prevented further conflict but further contributed to their moral distress (Sundin-Huard & Fahy, 1999). Some nurses felt intimidated and feared retribution that silenced the nurses, this silence contributed to the development of moral distress (Gutierrez, 2005).

Inability to Prevent Death

Events that concluded with the unexpected or sudden death of the patient, despite the nurse's best effort, contributed to the development of moral distress, especially when the nurses felt powerless to avert the patient's death. Events that the nurses described as "catastrophic" were events that caught the nurse unprepared and left them wondering why such an unexpected death occurred. These unexpected events frequently left nurses wondering if they could have done something else to change the outcome. Nurses frequently wondered about their actions and inaction. Even if there was nothing the nurse could have done, in some of the situations the nurses still developed moral distress and felt "haunted" by the event (Gunther & Thomas, 2006).

Impact and Consequences of Moral Distress

Since Jameton's initial description of moral distress as painful feelings and psychological disequilibrium, the concept of moral distress has evolved to include feelings of anger, frustration, and anxiety. Furthermore, those care providers who are unable to cope with feelings of moral distress not only develop professional problems but personal problems as well. Those with moral distress describe the personal effects of feeling worthless, angry, frustrated, depressed, ashamed, sad, disgusted, guilty, and even feelings of lost self worth and self-confidence (Wilkinson, 1987/1988; Webster & Bayliss, 2000; Corley, 2002; Gutierrez, 2005; Haggstorm, Mbusa & Wadensten, 2008).

The feelings related to moral distress also invaded nurses' home lives because they "couldn't turn off" the negative feelings. Nurses described feeling short tempered, grouchy and irritable with family, while others questioned their own beliefs (McClendon & Buckner, 2007). Some described uncontrollable crying, nightmares, loss of sleep and even physical symptoms of

heart palpitations, neck pain, muscle pains, stomach problems, diarrhea and headache (Wilkinson, 1987/1988; Corley, 2002; Gutierrez, 2005; McClendon & Buckner, 2007).

Dispirited professional life has also been identified as a consequence of moral distress; this has included a lack of focus and patience while at work, feelings of decreased job satisfaction and “burnout”. Some nurses have attributed moral distress to their decision to change positions or leave the profession (Deshpande, 1997; Corley, 2002; Hamric & Blackhall, 2007; McClendon & Buckner, 2007).

Jameton’s initial definition of moral distress suggested the experience of moral distress was restricted to nurses. Since then moral distress has been shown to occur in physicians, social workers, pharmacists, and health care administrators. Nurses however have been shown to be more vulnerable to the development of moral distress (Kalvemarm et al, 2004).

The consequences of moral distress are detrimental to both the care provider, the patient, the organization and the community. Moral distress has been associated with reluctance to work, job dissatisfaction, decreased interaction with patients and families, employee turnover and burnout (Gutierrez, 2005; Erlen 2001; Bruce, Conaglen & Conaglen, 2005). Moral distress is a major contributing factor in staff shortages, with some studies estimating that at least 25% of nursing job turnover is due to moral distress (Hamric, 2000). Job turnover because of moral distress is thought to create a “negative feedback loop” with the remaining staff facing higher workloads that further contribute to the development of moral distress.

Coping with Moral Distress

The ability of nurses to cope with moral distress depended on the circumstances that prompted coping and the quality of the nurses coping skills (McClendon & Buckner, 2007).

Hanna (2005) found that some coping strategies used by nurses experiencing moral distress included avoiding future experiences causing moral distress, having “deep self-conversations”, taking long walks and reflecting on their actions, deciding against future involvement in distressing events or setting limits and informing their employers, deep breathing exercises, prayer, relaxation techniques, use of alcohol, drugs and other escape behaviour, and denial (Hanna, 2005).

Some nurses spoke with their colleagues about the morally distressing event. Often these discussions took place at coffee break or during shift report. Most often these informal discussions were with other nurses although sometimes the discussion took place with a family member, physician, or social worker (McClendon & Buckner, 2007; Silen, Tang, Wadensten & Ahlstorm, 2008).

Many nurses thought that their coping skills were inadequate when confronted with issues causing moral distress; most nurses thought that this was because they were young and inexperienced. Strategies to develop effective coping strategies for moral distress include the development of a forum for ethical discussions, improving communication and collaboration between patient, family, and the health care team, and improve nurses’ access to and involvement in deliberations that have a major impact on moral distress (Sundin-Huard & Fahy, 1999; Oberle & Hughes, 2000; Corley, Minick, Elswick & Jacobs, 2005; Gutierrez, 2005; Hanna, 2005).

Moral Distress across Nursing Specialties

Moral distress occurs throughout the continuum of care in a variety of clinical settings and across nursing specialties. Typically the nursing literature has focused on practice settings in

acute and critical care settings with smaller clusters of literature in obstetrics, palliative care, and psychiatric settings. There are very few studies based on long-term care settings and research that focused on non-acute continuing care settings. The literature was reviewed in terms of the practice settings in which nurses provide care to understand if there were differences in the experience of moral distress, depending on the patient population or setting.

Commonalities across nursing practice settings. Across all nurses' practice settings a common cause of moral distress was inadequate resources to meet their patients' need or to meet the practice expectations of the nurses. Resources including experiences that revolved around the amount of financial resources allocated and how those resources were spent. Resources also included the lack of human resources across all practice settings. Lack of time and staff resulted in staff being forced to prioritize their time between tasks that seemed equally important and resulted in a concern that spending too much time with one patient means the others will have to wait. Work levels that nurses' thought were 'unsafe' as a result of low staffing levels occurred frequently across practice settings, inadequate staffing to meet the needs of the acuity and census was identified as very morally distressing for the nurses (Sundin-Huard & Fahy, 1999; Oberle & Hughes, 2000; Austin, Bergum, & Goldberg, 2003; Kalvenmark, Hoglund, Hansson, Westerholm & Arnetz, 2004; Corley, Minick, Elswick & Jacobs, 2005; Green & Jeffers, 2006; Gunther & Thomas, 2006; Hamric & Blackhall, 2007; Rager Zuzelo, 2007; Silen, Tang, Wadensten, & Ahlstorm, 2008) .

Medically futile care was identified in all care settings as a cause of moral distress. Nurses across practice settings cited that caring for patients who were suffering for prolonged periods of time and with poor outcomes or quality of life caused moral distress. Over treatment,

prolonging death, excessive and meaningless care of patients resulted often in the development of moral distress among nurses providing or witnessing the care. Nurses felt that extending false hope by resuscitating or providing aggressive treatment to patients that were clearly in the last stages of life with no hope of recovery caused moral distress in the care provider (Hefferman & Heilig, 1999; Corley, Elswick, Gorman, & Clor, 2001; Cronqvist, Theorell, Burns & Lutzen, 2004; Corley, Minick, Elswick & Jacobs, 2005; Gutierrez, 2005; Ferrell, 2006; Green & Jeffers, 2006; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Rager Zuzelo, 2007; Rice, Rady, Hamrick, Verheijde, & Pendergast 2008).

Physician and nurse working relationships were identified as a common source of moral distress among nurses working in all practice settings. Sources of distress within the physician and nurse relationship included cultural factors such as a perceived disparity in goals between medicine and nursing in which there seemed to be a philosophy of “care” among nurses and a philosophy of “cure” by physicians. Nurses often perceived that differences in values between nurses and physicians constrained nurses from acting on their beliefs. Another cultural element identified was a power differential between nursing and physicians (Hefferman & Heilig, 1999; Sundin-Huard & Fahy, 1999; Oberle & Hughes, 2000; Gutierrez, 2005; Rager Zuzelo, 2007)

Nurses identified that their perceived ‘lower’ position in the hierarchical structure as a source of their moral distress: not being listened to by doctors; being expected to be silent even when witnessing wrong choices; being unable to have an impact on decisions despite their professional assessment and in-depth understanding of the patient’s condition (Oberle & Hughes, 2000; Gutierrez, 2005; Rager Zuzelo, 2007). Delayed interventions as a result of physician

inattentiveness, lack of communication, or slow response led to moral distress in the nurse (Hamric & Blackhall, 2007; Silen, Tang, Wadensten & Ahlstorm, 2008).

Findings specific to practice settings. Moral distress in nurses working in acute or critical care settings experienced thoughts about leaving the profession of nursing, leaving their position, reducing their worked hours in a week, and some were reluctant to come to work and experienced an emotional withdrawal from the patient (Hefferman & Heilig, 1999; Elpern, Covert & Kleinpell, 2005; Gutierrez, 2005; Gunther & Thomas, 2006).

When physicians were reluctant or unwilling to increase dosages of pain medication because of potential pharmacological side effects, nurses continued to provide care to patients who continued to experience pain. When nurses were unable to meet the patient's basic need for pain relief; the nurses' inability to reduce the patient's suffering resulted in their own suffering experienced as moral distress (Oberle & Hughes, 2001; Rice, Rady, Hamrick, Verheijde & Pendergast, 2008). The nurses' experience of moral distress as a result of not being able to relieve their patient's pain was unique to nurses providing care to palliative patients.

The lack of an established therapeutic relationship between a nurse and their patient was a source of moral distress among nurses practicing in mental health. Mental health nurses were distressed that they did not have enough time to really know their patients and develop a therapeutic relationship. The nurses indicated that they did not have time to learn about their patients resulting in the nurses only knowing the patients' names, diagnosis and what medications were prescribed. The participants were distressed because they believed the art of nursing had gone, and therapeutic relationships should be the foundation of psychiatric

treatment. The nurses believed that they needed to understand their patients' fears, hopes and desires to get well but were unable to do this (Austin, Bergum & Goldberg, 2003).

Summary of the Literature Review and Conceptual Model

In summary, moral distress is the emotional and mental distress that accompanies and results from not being able to act in accordance with one's values and beliefs, and not being able to act in accordance with one's moral conscience. The impact of moral distress can present as feelings of pain, headache, sleep dysfunctions, tiredness, and sorrow, loss of self-worth, depression, anxiety, powerlessness, shame, grief, dread, heartache, and anguish. Moral distress in nurses has been attributed to reluctance to work, job dissatisfaction and turnover. The psychological disequilibrium and negative feelings that nurses experience with moral distress pose a major problem for them and their patients directly as it compromises nurses' ability to provide care and impacts the nurse's personal and professional lives.

The review of the moral distress literature describes the experience of moral distress in detail, but it also became apparent that there is also a process of moral distress embedded in the experiences. The process in which a nurse experiences moral distress begins with the identification of a moral conflict and continues through the phases of moral distress and a return to psychological equilibrium. A conceptual representation of the process of moral distress has been developed from the moral distress literature (Figure 1).

The conceptual model was developed in an attempt to organize the common elements, thoughts, feelings, and steps in the process of moral distress as identified in the nursing literature. The conceptual model of moral distress served as a snapshot of the existing literature available on moral distress among nurses and provided a basis for the development and exploration of

moral distress in non-acute continuing care nurses. Once data collection was complete it was the intention of the researcher to use the model to compare the common elements, thoughts, feelings, and steps in the process of moral distress in the non-acute continuing care nurse.

The existing moral distress research focuses on limited areas of nursing practice. There is a large growing base of research about moral distress examined in acute care, particularly critical care nursing, but little in areas including mental health, palliative care, long-term care and maternity nursing.

The literature indicates the importance and significance of moral distress and its effect on nurses and patient care. With an identified gap in research of some nursing practice settings I decided to focus on Registered Nurses practicing in non-acute continuing care settings. With the aging population and people living longer with complex health needs there will be a growing need for non-acute continuing care and nurses to provide that care. As such, it becomes increasingly important to identify causes and consequences of moral distress so that policy and interventions can be developed to mitigate them.

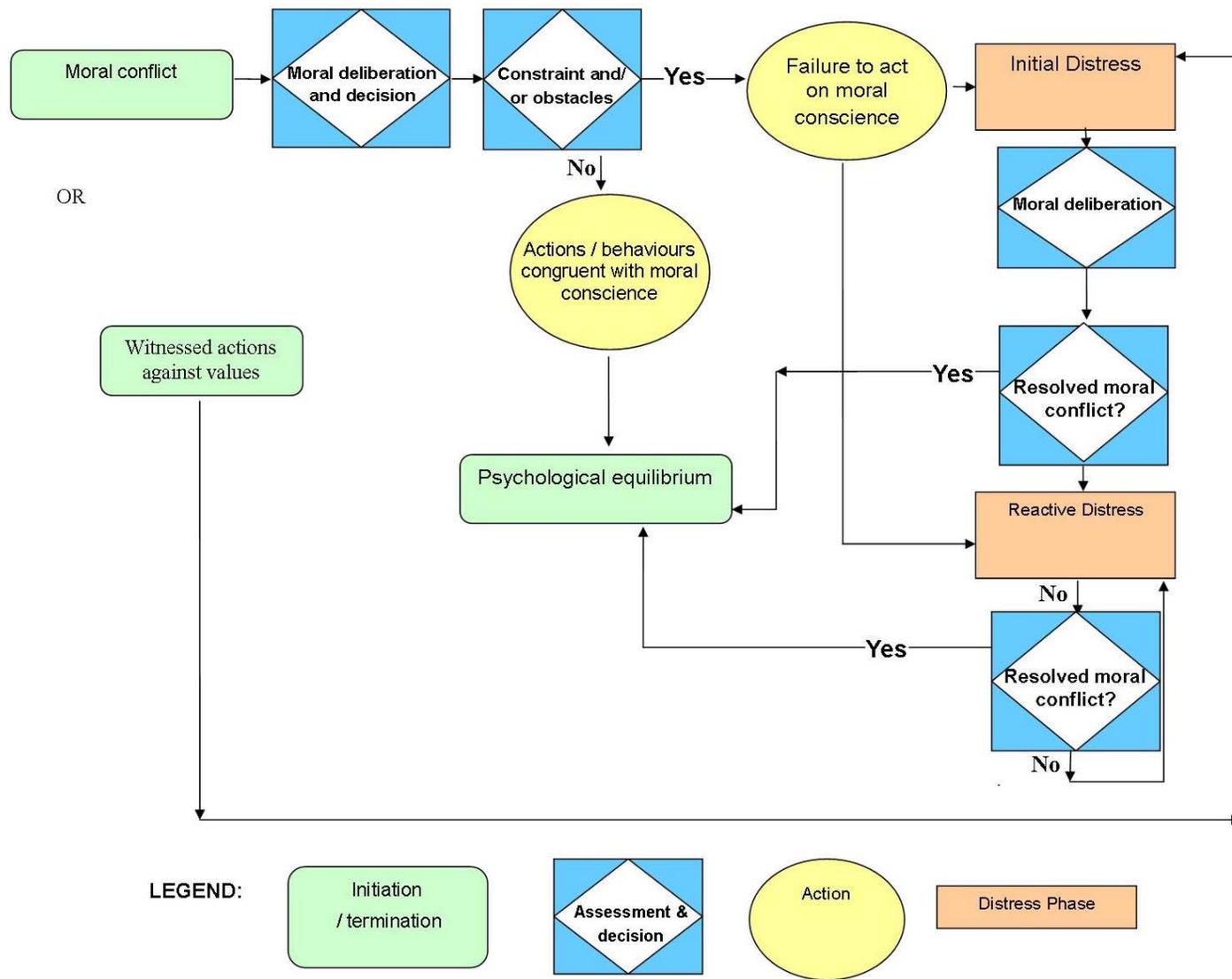


Figure 1. Conceptual Model of Moral Distress Experiences among Nurses

CHAPTER 3

Methods

This study examining the experience of moral distress among Registered Nurses who practice in non-acute continuing care settings was part of a larger study of hospital clinical ethics committees and nurses and physicians use of these committees. The larger study is being conducted by Dr. Alice Gaudine, Dr. Linda Thorne, Dr. Sandra Lefort, and Dr. Marianne Lamb and is entitled: “The Functioning of Hospital Ethics Committees for Clinical Practice and Nurses’ and Physicians’ Use of These Committees”. The larger study examines four hospital ethics committees (HEC) from the perspective of the ethics committee members, physicians, nurses, and other key informants. Specifically, data collection for this thesis research occurred concurrently with a phase of the larger study that involved interviews with nurses who work in the continuing care setting, but who are not members of the hospital’s ethics committee.

Purpose

The purpose of this study was to describe the experience of moral distress of nurses who work in non-acute continuing care settings. Continuing care setting is a term used to define a health care environment that provides 24-hour nursing care to patients who may be close to the end stage of their disease process and who often have multiple needs. These patients have an established diagnosis but require ongoing nursing care, evaluation, technical assistance, close monitoring, and treatment. The patients may have had an acute medical condition that has stabilized or are in the end stage of a chronic disease process.

Research Questions

The questions of the study were:

1. Do nurses in continuing care settings experience moral distress and if so, in what kinds of situations?
2. What is the experience of moral distress for nurses working in continuing care settings?
3. What are the consequences or results of moral distress experiences?

Design

The research purpose and central questions led the researcher to use a qualitative descriptive approach within the tradition of naturalistic inquiry. The naturalistic paradigm assumes that no single reality exists and rests firmly on the notion that “shared constructions, developed collaboratively by empowered individuals are the basis for significant cross-cultural and interpersonal understandings” (Erlandson, et al., 1993, p. xvii) Naturalistic inquiry allows methods to evolve during the course of the research rather than being predetermined before the research.

In a qualitative descriptive approach, sometimes referred to as a fundamental or surface qualitative description, the findings of a study are described as presented to the researcher with minimal theorizing. This is in contrast to other qualitative methods such as phenomenological, theoretical, ethnographic, or narrative descriptions. In these latter approaches the researcher interprets and theorizes about the findings. According to Sandelowski (2000), qualitative descriptive studies can be considered as the least “theoretical” of qualitative approaches as there are minimal methodological frameworks and theoretical and philosophical commitments. In qualitative descriptive studies, there may be some level of interpretation in similarity to other qualitative methodologies; however, the main purpose of qualitative description is to produce a

“thick” descriptive summary of an event based on the data collected. The descriptive summary itself may generate working concepts, hypotheses, and thematic moments (Sandelowski, 2000).

Setting

The nurses who participated in the study provided care to inpatients at a continuing care organization that offers a range of clinical services to patients across southeastern Ontario. This fuller description of the setting is one of the ways in which a subsequent researcher may consider the transferability of the findings to another setting. The researcher collected data from two sites with 332 inpatient beds across the sites providing care to patients with complex continuing care, palliative care, mental health, rehabilitation, and specialized geriatric care needs.

Nurses practicing in the complex continuing care unit provide care for adults who require 24-hour nursing care. Patients are close to the end stage of the disease process and often have multiple needs that require ongoing assessment and treatment. This unit also includes respite beds to provide relief to families who are caring for a relative at home, and who would meet the admission criteria for complex continuing care.

The mental health units include forensic services and geriatric psychiatry. Both units provide mental health care to patients whose acute mental illness has stabilized, but who still require ongoing care, assessment, treatment, and rehabilitation. The patients continue to participate in rehabilitation activities as they work towards reintegration into the community. Nurses practicing in geriatric psychiatry provide inpatient care for older persons with severe mental illness, cognitive impairment and behavioural disturbance. The forensic program provides ongoing care to people with severe psychiatric illness who have been in conflict with the law.

The palliative care unit provides care to patients in the final stages of life. Nurses provide care to patients in their final stages of a terminal illness, in which no life-prolonging interventions are available, offered, or expected. These patients have nursing care needs that can no longer be met in the community and require intensive symptom assessment and management.

Specialized geriatric and rehabilitation units provide care to patients who have suffered from an illness or injury. Nurses practicing on these units focus on the development of a comprehensive program that addresses medical illness, social functioning, emotional support and vocational assistance.

Participants

Inclusion criteria. The population of interest for this study was Registered Nurses practicing in a non-acute continuing care hospital. Participants of particular interest were Registered Nurses who had experienced moral distress, who were willing to talk about their experience, and who represented a range of clinical practice settings in one multi-site non-acute continuing care organization. The inclusion criteria were as follows:

1. Registered Nurse.
2. direct care provider or a nursing administrator
3. practicing in one of the following non-acute hospital settings: mental health, complex continuing care, rehabilitation, or specialized geriatrics.

The participants were determined to have met the inclusion criteria prior to and during the interview.

Recruitment and sampling. In order to obtain suggestions on the best ways to approach and recruit nurses for the study, the researcher attended a meeting of clinical and operational

leaders at the target organization. The researcher then posted advertisements (Appendix A) and a description of the study (Appendix B) in the nursing report rooms of targeted nursing practice areas. As well, the researcher consulted with nurse managers in the targeted practice areas to discuss how they might inform nurses of the study and facilitate researcher contact with potential participants. The researcher used a convenience sample supplemented with “snowball sampling” to recruit participants. Snowball sampling involved asking participants who volunteered for the study to identify other potential participants from their practice area. Once identified, the researcher contacted the potential participants by e-mail or telephone to determine their interest. The researcher also attended staff meetings of the targeted practice areas to discuss the study and ask for participants that met the inclusion criteria.

The researcher aimed to recruit 10 Registered Nurses as participants in the study, with two clinical nurses from each subset of the non-acute continuing care patient care areas: complex continuing care, palliative care, rehabilitation, mental health, specialized geriatrics. An additional two nurses in a manager role were sought to gain the managerial perspective on moral distress in non-acute continuing care. It was anticipated that a sample of ten participants would not be too small that it would be difficult to achieve data saturation while, at the same time, the sample should not be too large that it is difficult to undertake a deep analysis (Sandelowski, 1995).

A variety of approaches were used to gain access to the non-acute continuing care nursing population. The researcher posted recruitment advertisements and attended staff meeting on target units. After attending staff meetings and posting advertisements the researcher had significant difficulty recruiting participants. The researcher then explored personal and

professional contacts, approached staff on the unit, attended morning report on the unit, and sought potential participants from nurse managers, directors and vice president of programs. After five months of recruitment there continued to be a lack of response to participate, after exhausting a snowball method the researcher concluded data collection with eight participants.

Data Collection

Data were collected using a semi structured interview guide (Appendix C). The interview guide was based on the following definition of moral distress:

Moral distress involves situations in which nurses cannot fulfill their ethical obligations and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice (Webster & Baylis, 2000, p. 217).

Prior to conducting a participant interview, the researcher conducted a practice interview with a graduate student colleague who was also a Registered Nurse with a clinical nursing background. After the practice interview the audiotape was reviewed with the researcher's thesis supervisor to identify changes to interview approach and techniques.

Semi-structured interviews were conducted in a private location where the participant indicated they would feel comfortable discussing their experiences. Interviews were conducted in private rooms and offices of local hospitals and were audiotaped with the permission of the participant. The interviews ranged in length from one to one and one half hours; the average interview length was one hour. Demographic data were collected on the participants to determine the characteristics of the participants and health care setting. The researcher then asked direct

questions for the interview that lead the participants to explore the sources of their moral distress as well as identify their experiences in the initial and reactive phases of moral distress.

Field notes were taken during and directly after each interview to record details about the interview. They were used to keep a running account of what was occurring during the research process. Entries included challenges, ideas, self-reflections, personal feelings, reactions, biases, and impressions in the data collection and recruitment process. The field notes were later used to explore possible influences on the data and the effects of personal events to the data collection and analysis. Emergent trends and themes were documented to guide in later analyzing the data (Strauss & Corbin, 1998).

Phase 1 the “orientation and overview phase” of the study included the researcher’s initial face-face semi-structured interview (Appendix C) with the participants, which involved asking the participants to tell the researcher what he needs to know about their experiences of moral distress. The object of this phase was for the researcher to gain an understanding of what is important and needs to be followed up in detail (Lincoln & Guba, 1985). Lead questions (see questions 4-7 in Appendix C) were asked initially to guide the researcher in capturing the participant’s experience of moral distress. Exploratory questions such as who, what, why, where, and when were used to elaborate on the participant’s experience. Phase 2 was “focused exploration” and “member check”. Individual participant interview transcripts were given back to the participants. Participants were asked to scrutinize the written transcript. Here confirmation was obtained that the written transcript captured the participant’s experience. At this time participants were given the opportunity to clarify or expand on any content of the transcript. The participants were given the opportunity to request a second interview to clarify information in

their transcript. The researcher conducted a second interview with one participant to clarify and expand on some of the content in the first interview. Through this member check phase credibility and trustworthiness of the data was established (Lincoln & Guba, 1985). During this phase the researcher may have also contacted the participants for follow-up questions to further explore and obtain in-depth information that is determined to be significant (Lincoln & Guba, 1985).

Analysis

On completion of a written transcript of the interview, the transcripts were reviewed several times and the initial interviews were hand coded by both the researcher and supervisor. These initial codes were discussed prior to the subsequent coding all of the interviews using NVivo software. The process began with open coding and then codes were collapsed into categories that would assist in the description of the nurses' experiences and that addressed the research questions.

Trustworthiness

Naturalistic inquiry must meet trustworthiness criteria described by Lincoln & Guba (1985): credibility, transferability, dependability, and confirmability. Credibility or degree of confidence in the 'truth' of the findings of the inquiry is achieved by ensuring that a rich, thick description of phenomena is provided (Lincoln & Guba, 1985). Establishing credibility included the use of open ended interviewing techniques and using established questions to guide the researcher in the interview. Further, the credibility of the research was established through member checking (described later), and consistency with the naturalistic inquiry approach (Krefting, 1991).

Transferability. The transferability of the research findings in another context or with other respondents has been established by obtaining depth, richness, and detail of the moral distress phenomenon in continuing cares nurses. Through a thorough description of the research procedures, methods, settings, circumstances, and participants the research findings may apply to other circumstances outside the research study if the reader has determined the appropriateness of transferability.

Confirmability. Confirming the research and its findings are the product of the focus of the research and not biased by the researcher (Erlandson et al., 1993). Through reflection of the researcher's preconceptions, the researcher can suspend or set aside all prejudgments about the phenomenon through "bracketing" until they can be founded on a more certain basis; that is to understand the phenomenon from the voice of the participants (Creswell, 1998). In order to clarify my motivations and rationale for pursuing this area of research I will describe my personal experiences, beliefs, assumptions, and preconceptions about the research topic. Once these descriptions are put into writing they can be used for self-reflection and for external review.

Member checks in which confirmation that the written transcript captures the participant's experience were obtained. During the interview with the researcher, the participants were informed that they would have an opportunity to review the interview transcript for accuracy and to clarify or expand on content of the transcript. After the interviews were transcribed, the transcript was delivered to the participant in a sealed envelope, or if the participant requested it, it was delivered in a password-protected email. Letters thanking the

participants for their participation in the study and instructions on the member checking process were given.

Ethics

The study proposal was reviewed and approved by the Queen's University Research Ethics Board (Appendix D) and the research review committee of the organization in which the study was conducted. The consent form and details of the study were discussed in person by the researcher and the participant. Written consent to participant in the study was obtained from each participant (Appendix E).

Chapter 4

Findings

In this chapter, a description of the participants has been provided followed by a description of the research findings. The findings have been organized in terms of the research questions and themes related to those questions. A description of the moral issues faced by the nurses in the continuing care setting is followed by the description of the experience of moral distress for nurses and the consequences and result of their moral distress experiences.

Subheadings used to organize the findings include: participant characteristics, do nurses in continuing care settings experience moral distress and if so, in what kinds of situations, what is the experience of moral distress for nurses working in continuing care settings, and what is the consequences or results of moral distress experiences.

Participant Characteristics

The eight nurses in the study ranged in age from thirty-one to sixty years. The average number of years in the nursing profession was twenty-two years, with an average organizational tenure of thirteen years. Seven of the eight participants were female. Three nurses worked in complex continuing care, two in specialized geriatrics and three nurses in mental health. Five of the participants were direct care nurses, one nurse was an advanced practice nurse and two participants were nurse managers. Further description of the participant characteristics are summarized in Table 1.

Do nurses in continuing care settings experience moral distress and if so, in what kinds of situations?

Most, of the nurses interviewed reported that they had experienced a situation that gave rise to moral distress.

Table 1

Participant Characteristics (N= 8)

Characteristic	N	%
Age (years)		
31-50	4	50
51-60	4	50
Gender		
Male	1	12
Female	7	87
Education		
Diploma	5	62
Baccalaureate	3	37
Years in the Profession		
5-10	2	25
16-25	2	25
26-40	4	50
Work Domain		
Direct care	6	75
Management	2	25
Clinical Setting		
Complex Continuing Care	3	37.5
Specialized Geriatrics	2	25
Geriatric Psychiatry	3	37.5

There were two participants who stated that they did not experience moral distress. One of the nurses had thirty-six years of nursing experience and the other nurse had six months of experience in her current position but she had previously been in the setting for ten years, which was interrupted by a position in an acute care setting. This nurse described moral distress from her experience in acute care. Although both participants stated that they had not experienced moral distress in non-acute continuing care, they did describe moral conflicts and distressing situations that were consistent with what the literature identifies as moral distress.

The other participants described situations that gave rise to moral distress depending on their nursing role, either manager or providing clinical care. Nurses who were in a manager role described distress that involved the team and organizational functioning and clinical nurses described situations involving patient care, wellness and autonomy. Nurses in a manager role described ethical problems involving their staff and care teams. The problems involved team and organizational functioning, as well as the work environment in the area for which the participant was responsible. A nurse manager described a situation that involved a verbally and physically abusive patient and how the patient's behaviour affected the area for which the manager was responsible:

The patient ... he really pitted one (nurse) against the other. There was a cohesive staff that was ripped apart and it was staff member against staff member. There were people calling in sick, saying they weren't coming to work (Nurse one).

The nurse managers were also aware that the ability to manage situations and make decisions directly affected the front line provider and patient.

My immediate supervisor...was a real bully and there were issues that arose during that time she was here because of the negative impact of her behaviour and her decision making...it was not good mix for the organization and I know that things were done and instituted that were not in the best interest of the organization, weren't the best for the teams. For 21 years you always work to keep patients and co-workers in the forefront and try and make decisions that benefit the long-term patients and staff. To see someone come in and basically destroy it in seven or eight months [it was] heart breaking because it's not what our organization is about (Nurse two).

One nurse described a difficult situation involving a patient who was perceived to be manipulating the staff to alter the care plan. Despite the nurse manager's best efforts she was not able to "get a handle on it fast enough" and effectively manage the situation with the resources available to her. The situations quickly manifested into a more complex and "all consuming" situation in which there was "conflict among the nurses themselves, conflict to the team, and conflict with the patient".

Nurses practicing in clinical roles described situations leading to moral distress that involved direct patient care instead of team functioning. The ethical problems ranged from end of life decisions to resource utilization. The nurses thought that without their intervention the patient's quality of care was at risk. One nurse described a situation in which she thought her colleagues were inappropriate in their care:

There was a fellow that did really upset me, who had a diagnosis of Addison's disease on top of the dementia and was walking but very often falling on the floor and being kind of disorientated. The staff decided that this was "behavior" and they didn't respond to his

lying on the floor and I was really upset by that because I thought that he was falling was relating in a drop in blood pressure. I almost thought that it was abusive and so what I would do is, whenever I saw the situation I would help him to his feet and I would intervene...I thought okay, these people don't know about Addison's disease and they don't know that it could potentially be hypotension, so I thought we need to have clinical rounds on the ward so they can see this differently and so I asked for the program manager to organize clinical rounds and she did (Nurse four).

Another nurse described an ethical problem of a colleague ignoring and going against a patient's wishes:

The other nurse was more senior to me at the time and she was demanding that we do things above what the patient had wished. She wanted to [resuscitate], she was going to call a code when I mentioned to her that this patient was a no code situation and it got very irritating to both of us, because we had a two minute debate a professional debate over, "are you just going to let her die?"...It was in complete conflict to the patient's wishes. Once she had been able to speak, she had wanted the dignity and end of life care. I did not feel that I could morally go against the patient, to me then it almost is assault (Nurse Five).

What is the Experience of Moral Distress for Nurses Working in Continuing Care Settings?

Those participants who described moral distress described obstacles in acting in accordance with their moral conscience, initial moral distress and moral deliberation.

Participants who did not resolve their initial moral conflict experienced persistent moral distress.

Initial distress. When the nurses were asked about their initial feeling during an ethical

problem, the nurses described feelings that ranged from anger and frustration to sadness. When describing initial distress, nurses portrayed the experience as very intense and emotional. Nurses used words such as being “ripped apart”, “all consumed”, “frustrated”, and “bullied”, “intimidated”, pitted against one another. Powerful phrases used to describe initial distress included: “I was sorry, sorry...” “I was really torn”, “I have to protect this guy [patient], and I’ve got to protect him somehow”.

One nurse described her feelings when decisions were made that she believed were not in the best interest of the organization and her staff. She described working for years making decisions that were in the best interest of the patients and staff that she felt sad to “see someone come in and basically destroy it in seven or eight months is heart breaking because it’s not what our organization is about”. Some nurses expressed their feelings of fear associated with the distressing event. One nurse described a situation in which he was injured at work; his superior had ordered him to stay at work despite his belief that he could not perform fully in the capacity of a nurse:

Nursing Coordinator ordered me to stay on the job, and in my opinion I shouldn’t be there, I believed I was putting clients at risk...I was afraid. I was afraid for them, I was afraid for my nursing license, I was afraid for a lot of stuff (Nurse three).

Another nurse described feeling discouraged and upset in a situation in which there were several admissions during her busy shift and she was unable to provide the quality of care that she would have liked related to an increased workload.

Nurses experiencing moral distress also described their thoughts during the event, which ranged from concern to powerlessness. Some of the nurses’ recalled their thoughts of feeling

bullied. One of the nurses described his thoughts when encountering the event as “oh my God; what if somebody falls, and I can’t even pick them up. I really felt that I was endangering people”. Another described her thoughts initially as being “out numbered” by her nursing peers. She thought that she needed to “get around” her co-workers to act in the best interest of the patient. Nurse two described her feelings when she thought that she was being bullied:

My immediate supervisor, well to put it politely she was a real bully...[I felt] powerless, frustrated, and actually sad, I mean as much as it upset me, the decisions made really affected my staff, and that really annoyed me. It makes you sad because you think to yourself, you know geeze you’ve worked for the organization for 21 years and you know you have always kept your patients and your co-workers at the forefront (Nurse Two).

Moral Deliberation

When nurses encounter an ethical problem they begin to deliberate and they describe a process that is both formal and intuitive. Formal moral deliberations among the nurses as described in the following three cases, involved consultation with other professionals for their interpretation and guidance and referral of the ethical issue to formal ethic committees, team meetings:

- We called an ad hoc meeting of the ethics committee; to discuss the entire situation...it was done in consultation with the family, with support from social work, psychologist and pastoral care. We then came up with a plan... it also included a follow up with the family, the team members, ongoing follow-ups with the team members as to what to expect, this is what were going to do and um

communicating with the physicians so...everybody was aware of what the plan was for this patient (Nurse two).

- We had staff meetings on the floor, meetings with the psychiatrist who was involved and then a sort of ethics committee meeting, not all of the members of the committee were there, but some of them (Nurse six).
- We had several meetings with the RNs and we involved [name-charge nurse], she gave us examples of “what would you do”, because she at that time was on our ethics committee, and she has really great knowledge on the working of the ethics and that’s how we resolved that problem (Nurse five).

Some nurses participated in a formal moral deliberation process although they did not articulate the moral principles used in their deliberation. This nurse described her thoughts and conversations with another nurse when deliberating on an appropriate course of action:

No code to me is very clear. No code they can determine no antibiotics, no extra fluids for IV’s or no resuscitation, no intubation... She said “and you get to let her die?” Um well what does a no code mean to you? Once [the patient] had been able to speak, she had wanted the dignity and end of life care. I did not feel that I could morally go against the patient, to me then it almost is assault (Nurse Five).

Although some of the nurses interviewed had knowledge of or were referred to the available structures to assist with moral deliberation, the majority were uncertain or unaware of structures such as hospital ethics committees or resources such as a clinical ethicist.

- They’re [hospital ethics committee] not as public as they should be...not available to everyone (nurse three).

- I presume that the hospital ethics committee would review situations with basic tenets in place...I don't know who is on the committee. I don't know where it is housed. I don't know anything about it really (nurse four).
- I know at one time when there was an ethical issue we could involve [name], a clinical ethicist. I know she has retired, but I'm not sure if they have hired someone else that we have access to... (Nurse one).

Obstacles and facilitators to moral conscience. Both clinical nurses and nurse managers identified that obstacles, constraints, institutional structures and other pressures sometimes lay in the way of doing what the individual believes is morally right. To the nurse it appeared as though the moral and right course of action was difficult to implement because of these perceived and actual obstacles. The obstacles that the nurses identified ranged from physical resources to behaviour and interactions with their peers:

- I felt out numbered, and I was really new. I was like maybe one month on the floor and them [the nurses] had a lot of power. I was trying to fit in... More often than not, I was out numbered. Yeah and I was new to the scene and they thought I was an airhead (Nurse four).
- Obstacles could be some of the physicians [I] hesitate to call ... [They say] "You're bothering me with this?" ... There have probably been times when [I thought I should call but] it was oh gee; I don't want to make that call because of which physician it is (Nurse six).
- Many of my patients have no visitors at all and so it's kind of connecting with another human being in maybe latter stage of their life...so that's kind of an

example of kinds of things beyond the obvious physical needs. I really see how discouraging it is...longer term care nurses are the ones who are expected to bear the brunt of higher patient loads and again less resources, even if we are just talking about seemingly trivial things like linen or capital budgets, like a T.V. (Nurse eight).

Some nurses also described the organization's hierarchical structure as an obstacle to moral conscience leading to moral distress:

- Being the person caught in the middle, I wouldn't, I couldn't go, I couldn't share that information with HR or at the VP level ...I didn't feel that I could (Nurse two).
- The nursing coordinator ordered me to stay on the job, and in my opinion I shouldn't be there, I believed I was putting patients at risk (Nurse three).

Persistent feelings. Nurses in continuing care settings described moral distress as thoughts and feelings at two points in time, when the nurse first experienced the event and sometimes long after the event had occurred. When asked about persistent feelings that lingered after a distressing event, some nurses described lingering thoughts and feelings. The two manager participants' experience of moral distress did not progress to persistent distress because their moral conflict was positively resolved.

Although less intense and emotional than initial distress, the nurses felt the ongoing effects of unresolved moral distress. The nurses described persistent thoughts after the distressing event that included the impression of being devalued, disappointment, regret and suspicion of others. Some nurses expressed persistent thoughts of regret surrounding their role in the distressing event. Nurse six described a situation in which she decided not to call a physician

to alert or ask a question about a patient situation because of the personality of the particular physician:

You know, most of the time we err on the side of caution you know, but there may have been times when in hindsight we wished we had made that call and didn't you know? Well sometimes we make those decisions as a group, some of the RNs will get together and you know we need to call about this, this, or this and maybe someone else like a couple of people might say well I think that can wait...here may been times when you know, I didn't and wished I had maybe. Sorry, sorry that I didn't [call]. I guess maybe just the fact once you maybe made a mistake or been sorry for something that you didn't do whatever, that down the road you kind of look at it differently and you make a different decision quicker (Nurse six).

Nurse four described her thoughts that persisted after a distressing event with a patient. Although the nurse advocated on the patient's behalf for changes to the patient's care plan she still had feelings of regret:

I've got to get around them; either we get this clinical focus group going tomorrow... you know I did not behave as I thought I should behave. I think I should have been more of an advocate for him (Nurse Four).

Another nurse who experienced a distressing event involving patient and staff safety described persistent thoughts that the nursing supervisor's decisions reflected not valuing the employees and the patients:

Yeah, I had a lot of negative feelings towards the nursing coordinators...that really left a negative impression on me; it felt like to me they didn't value the patients or their employees (Nurse Three).

Nurse eight described persistent thoughts of suspicion of administration after a distressing event in the distant past:

Sometimes even when they (administration) says something like 'oh we're going to have to do this' and I get really tense, like my God, what are they going to do now? I get really suspicious and kind of almost paranoid (nurse eight).

What are the Consequences or Results of Moral Distress Experiences?

Nurses in continuing care settings described the results or consequences of moral distress in terms of positive and negative outcomes.

Positive consequences. Positive outcomes ranged from changing practices to the expansion of knowledge among care providers, and change. Nurse one described how the distressing event resulted in growth and learning among the care team:

I think it was very difficult experience, but it was a really good learning experience. If that situation and it has come up since then and people are on it right and we are in this together, this is what we need to do and we have never come anywhere close to that ever again. So it was very difficult, but I think every single staff on that floor learned. The whole team learned too about support because there's been instances since that maybe one of the other disciplines has had an issue with one of the patients or could be family member either and even though you haven't experienced yourself, people remember back to that situation and relate, so I find there's much more support as a team in problem

solving and making sure that the whole team's doing the same thing, so its really been, it was difficult, very difficult, but it's really a learning experience and we've never let anything come to that again (Nurse one).

Another nurse described the education that occurred with the nurses as a result of the distressing event-involving end of life decision-making:

- [The charge nurse] gave us examples of what would you do in similar situations, because she at that time was on our ethics committee and she has really great knowledge. I found that it was probably was the best education that we could have done at that point, not only from the nurse that had probably 10 years experience and had never experienced an situation like this, but also it helped our younger staff who were fresh out of school and thought it's black and white. We got into what ifs and we had an open dialog and after that I think everybody felt more comfortable (Nurse five).

Nurse four described how after the distressing event, the nurses organized an education session and over time the culture and approach to care on the unit started to change:

- I thought okay, these people don't know about Addison's disease and they don't know that it could potentially be hypotension. So I thought, we need to have clinical rounds on the ward so they can see this differently. Since then time has passed and this whole trend of gentle persuasion with people who have dementia is beginning to have a visibility and they're beginning to bring that training to the staff and so there's a softening of attitude (Nurse Four).

Negative consequences. Negative outcomes of moral distress included conflict among team members during the distressing event and immediately afterwards. One nurse described how during the situation there was “conflict among the nurses themselves, conflict to the team, and conflict with the patient” and that it was “friends against friends”. Another nurse described a conflict with another nurse that occurred during the distressing event and continued after the event:

- Afterwards I know that our relationship took a little bit of time because I was upset with her for going above me. Even though she was in charge and she was annoyed that I wasn't following her commands that she felt we should do it, but it was in complete conflict to the patient's wishes...We agreed within an hour of it happening that we were going to disagree and if we had an uneventful night we were fine together (Nurse five).

Some nurses working in continuing care settings also described the consequences of moral distress from previous settings that continue impact their lives. The nurses with moral residue had experienced morally distressing events that never were resolved and resulted in the nurse leaving their employment. Despite a change in their employer and practice setting the nurses continued to experience ongoing negative feelings, thoughts and even physical responses when discussing or exposed to situations that reminded them of the initial distressing event. Nurses describe the lasting impact of moral distress experiences from an acute care setting despite moving to continuing care:

- Frustration then anything...hurt too. Nobody can give you the words to make you feel better; that you have lost that trust that you've built (nurse five).

- I mean it is almost like a post- traumatic stress disorder thing...you know what we are like battered abused women in a relationship.... [It was] so malicious that it just took my breath away and it even does frighten me to this day. I saw this person ... and I'm not kidding I felt [heart] palpitations. I thought oh my God this person can't be coming [to work here]...it scared me. I just reminded myself "calm down, its okay" (Nurse eight).

Of the eight participants interviewed six had experienced an event in their current position that they believed to be morally distressing. All of the nurses that experienced moral distress had experienced initial moral distress while only those who had not resolved their moral distress progressed to experience persistent distress. Some of the nurses in addition to experiencing moral distress in their current role continued to experience negative feelings and thoughts from settings where they had previously practiced. Although the individual experience of moral distress varied depending on the moral conflict and nurse, the process of moral distress as outlined in the conceptual model of moral distress in non-acute continuing care remained static.

Chapter 5

Discussion

This chapter will be presented in two sub-sections: fit between the existing moral distress literature and the research findings.

Fit with the Literature

The literature on moral distress includes both theoretical and empirical referents from a broad range of professional disciplines and clinical settings. The existing literature describes the experience and process of moral distress in areas other than non-acute continuing care settings that includes: 1) a person experiences or witnesses a threat, harm, or violation to their personal or professional beliefs and values; 2) the person tries to resolve the conflict between the situation and their values without success due to internal or external obstacles or constraints; 3) the person may experience emotional responses such as crying, trembling, feelings of anger and sadness, difficulty performing tasks, chest pain, dizziness, or nausea; 4) the person tries to avoid the situation in the future; 5) once the initial conflict with the person's values is resolved they return to a psychological equilibrium (figure 1).

The findings of this study indicate similarities to the current literature with some differences in the process and experience of moral distress in the continuing care setting. Moral distress is a situation in which the nurse's professional or personal values and beliefs are in conflict with the experience. The moral distress is based on the individual perspective of the nurse. Although nursing actions and behaviour are shaped by professional codes of ethics, experienced conflicts are based on the actual and ideal norms of the profession. Moral distress experiences were dependent on the roles in which the participants practiced, either as a manager

or clinical nurse. Nurse managers' distress revolved around team and organizational functioning and the work environment while clinical nurses' distress revolved around clinical interactions, care plans, and quality of care. These situations leading to moral distress in clinical nurses was consistent with the literature (Corley, Elswick, Gorman, & Clor, 2001; Corley, Minick, Elswick, & Jacobs, 2005; Gutierrez, 2005; Gunther & Thomas, 2006; Green & Jeffers, 2006; McClendon & Buckner, 2007; Rager Zuzelo, 2007; Silen, Tang, Wadensten & Ahlstrom, 2008). The literature on moral distress in nurse managers was limited, therefore it is undetermined if the findings in this setting is consistent with other practice settings.

Moral deliberation is the reasoning of what ought to be done in the face of a moral conflict (Isaacs & Jeske, 1997). This deliberation can be an explicit process in which the situation is critically examined and reviewed. Then an inventory of doubts and principles are taken, facts are reviewed and questions posed. The process of moral deliberation leads the individual to make judgments and determine the appropriate course of action (Smith, 2002; Molewijk, Verkerk, Milius, & Widder-Shoven, 2008).

Consistent with the moral deliberation literature, participants in this study used both formal and informal moral deliberation when encountering the moral conflict or while reflecting on the experience. Formal moral deliberations took place in the form of nurses formally reviewing their professional values, team meetings, ethics committees, and discussions with colleagues or those considered to be "experts".

After moral deliberation, either as an informal or critical review process the individual identified an appropriate moral course of action based on personal and professional values. Obstacles, constraints, institutional structures and other pressures sometimes lie in the way of

doing what the individual believes is morally right. Sometimes what appears to be the moral and right course of action is difficult to implement because of these perceived and actual obstacles, this makes the possibility of their decision difficult (Wilkinson, 1987/1988). The participants described a wide range of obstacles and constraints to their moral action including resources, conflicting values with other care providers, and organizational practices such as probationary periods, sick time replacement, and actions by management.

Initial distress is the result of a nurse knowing the morally right course of action, but because of obstacles or constraints the nurse fails to act in accordance with their moral conscience. Failing to act on their moral conscience leads to initial distress, which is characterized by a “physiological disequilibrium” initially after experiencing the conflict (Jameton, 1993). When the nurses were asked about their initial feeling during an ethical problem, the nurses in this study described feelings that included anger, fear, frustration and sadness. The nurses also described their thoughts during the event, which ranged from concern to powerlessness. Negative outcomes of moral distress in the current research included conflict among team members during the distressing even and immediately afterwards. These feelings and negative outcomes found in the current research findings are also consistent with the existing moral distress literature in other settings such as acute care, critical care, obstetrics, long-term care and psychiatry (Hefferman & Heilig, 1999; Sundin-Huard & Fahy, 1999; Austin, Bergum & Goldberg, 2003; Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Hanna, 2005; Green & Jeffers, 2006; Rager Zuzelo, 2007;).

Reactive distress develops after experiencing initial distress, the individual continues to be unable to cope with feelings of moral distress and is unable to resolve the moral conflict. The

feelings of distress further develop into negative personal and professional feelings (Wilkinson, 1987/1988). When asked about persistent feelings that lingered after a distressing event, the nurses described lingering thoughts rather than feelings identified in the literature. The nurses described persistent thoughts including the impression of being devalued, disappointment, regret and suspicion of others. The thoughts of being devalued and a sense of disappointment has been identified in the existing moral distress literature in care settings such as acute care, critical care, and psychiatry (Gutierrez, 2005; Rager Zuzelo, 2007; Austin, Bergum, & Goldberg, 2003), persistent thoughts of regret and suspicion of others was also identified in the existing moral distress literature in critical care and acute care nursing (Gutierrez, 2005; Rager Zuzelo, 2007; Sundin-Huard, & Fahy, 1999; Elpern, Covert, & Klienpell, 2005)

Other consequences of moral distress that have not been reported in the existing literature are the positive outcomes after moral distress. Nurses in this study identified positive outcomes that ranged from changing practices, expansion of knowledge among care providers, and change to the work environment.

Moral residue is an experience that is carried with the nurse from times in which they have faced moral distress and there has been serious compromise to personal or professional values (Webster & Baylis, 2000). In the literature moral residue seems to be viewed as an isolated phenomenon from that of the moral distress process and experience (figure 1), but in this study the results indicated that moral residue was a phase beyond that of persistent or reactive moral distress. Moral residue presented after a prolonged amount of time in which the nurse's moral distress had not been resolved (figure 2). Some participants described further consequences of moral distress from previous practice settings that continue to impact their lives.

These consequences included changing their practice setting, feelings of fear, and physiological symptoms such as heart palpitations and anxiety.

The conceptual model was developed in an attempt to organize the common elements; thoughts, feelings, and steps in the process of moral distress in non-acute continuing care nurses. As previously discussed the development of a conceptual model for moral distress among nurses was constructed from the literature (figure 1), organizing the findings of this study in a similar conceptual model provided consistent organization and allowed for a visual and conceptual comparison between the current and pre-existing research on moral distress.

The differences between the conceptual models (figure 3), the model constructed from the moral distress literature (figure 1) and the conceptual model constructed from the findings of this research study (figure 2), includes the initiation of the moral distress process. The literature identifies that when a nurse witnesses an action against their values, the nurse may experience initial moral distress. In this research none of the nurses described experiences of moral distress from witnessing actions against their values, all of the nurses were directly involved in the moral conflict where they were unable to act in accordance with their moral conscience. Another difference between the two conceptual models is that in this research the nurses' experienced moral residue that occurred from experiencing persistent distress for a prolonged period of time without resolution.

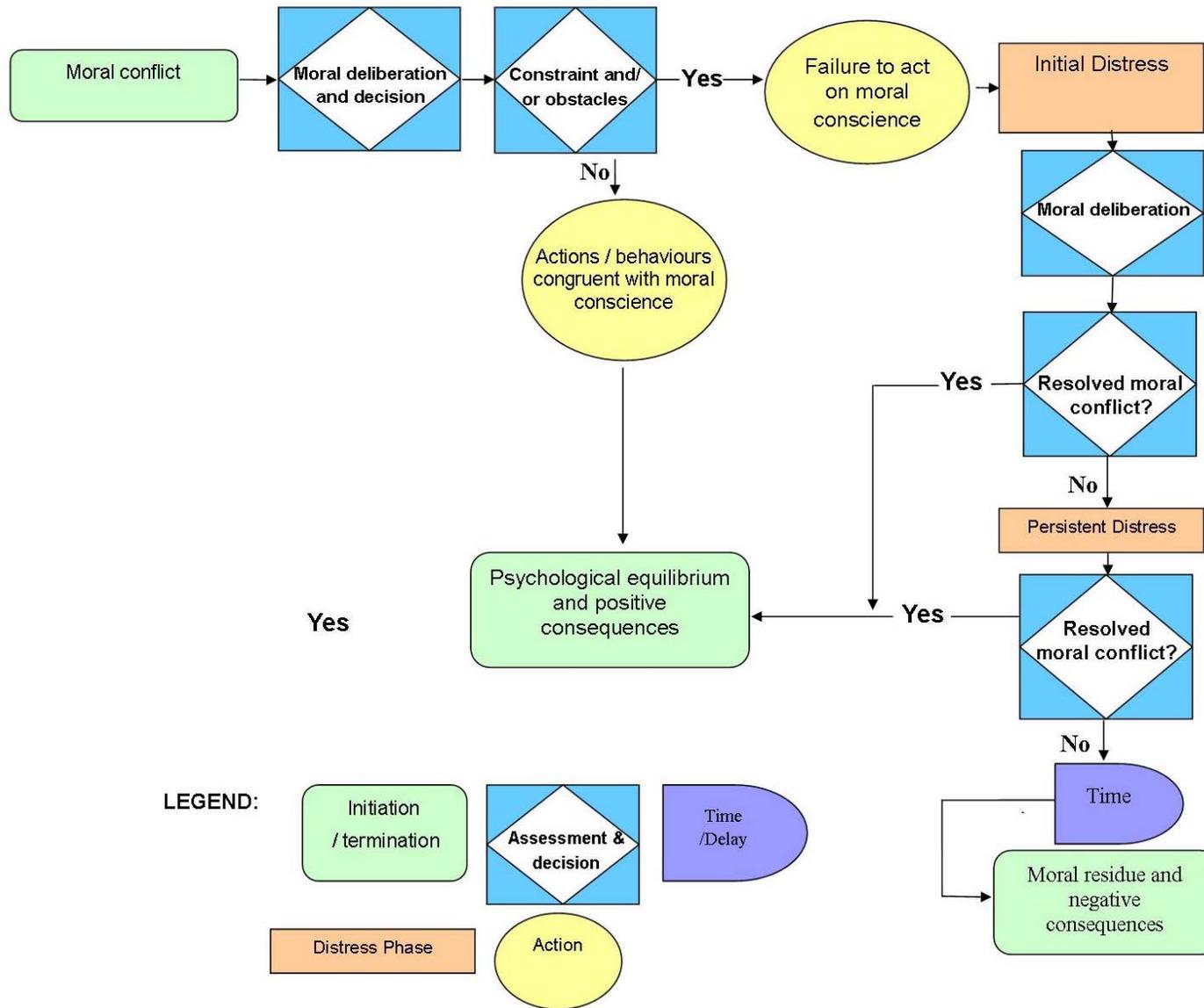


Figure 2. Conceptual Model of Moral Distress Experiences in non-acute Continuing Care

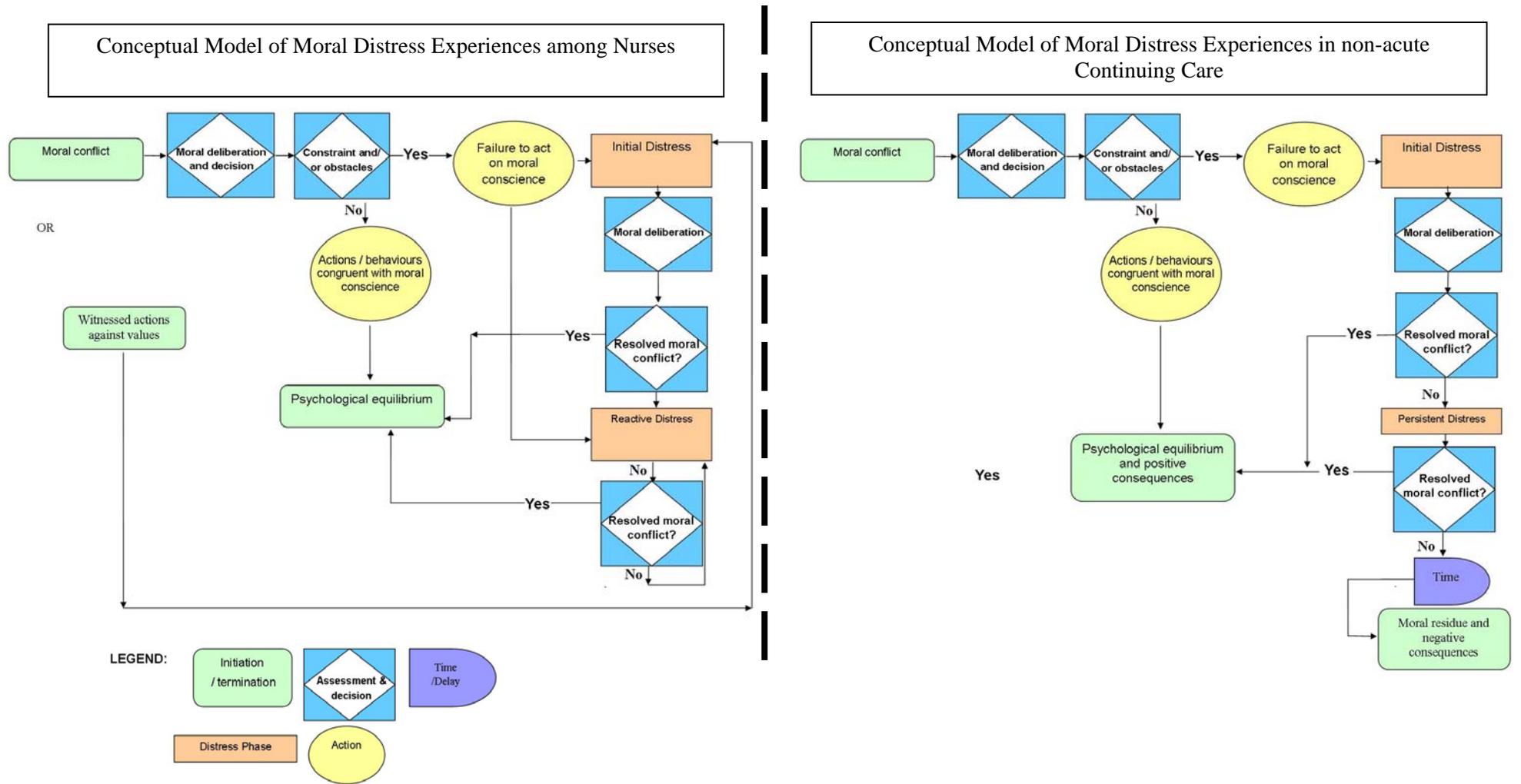


Figure 3. Comparison of Conceptual Models of Moral Distress

Chapter 6

Limitations, Implications and Summary

This chapter will be presented in six sub-sections: limitations, implications of the research findings, and implications for future research, education, practice, and administration. The final sub-sections will include a summary and conclusion.

Limitations of the Study

One limitation of this study was the small number of participants who were interviewed. The small sample size from the large diverse sector of non-acute continuing care may have produced findings that had not yet reached saturation. As such these findings may not present a full picture of the experience of moral distress in Registered Nurses working in non-acute continuing care settings.

Secondly, the majority of the participants were female. Since the profession is predominately female, this was not surprising, but men may experience or respond to moral distress differently, and there was only one male participant in this study.

Another limitation to this study is that the study participants were for the most part very experienced nurses; the average years in the nursing profession was twenty-two years. As experienced nurses the participants may have developed some strategies to protect themselves and prevent the development of moral distress. A younger, less experienced group of nurses may experience moral conflict and moral distress differently as their developmental level and strategies and coping techniques may develop over time and with experience.

Finally an ethnographic approach to examining moral distress in non-acute continuing care nurses may have revealed a thicker description and interpretation of the culture of the nurses, the moral conflicts that they experience, and the system in which the nurses work. By employing an ethnographic approach the researcher would have been able to observe participants in their day-to-day lives and one-on-one interviews over an extended period (Creswell, 1998).

Implications for Future Research

More qualitative research is needed on Registered Nurses working in non-acute continuing care settings to gain a better understanding of the experience and consequences of moral distress in order to further develop related theory and integrate into nursing practice. This study provides support to further explore, investigate, and fully understand the experiences of the non-acute continuing care nurse. Individualized study and exploration of the specific subsets of non-acute continuing care nurses would provide a clearer understanding of the Registered Nurse practicing in these settings such as continuing care, mental health, complex care, rehabilitation, and specialized geriatrics.

The current research recruitment methods were directed at nurses currently working in non-acute continuing care settings, nurses who had left the care setting were not recruited. Future research should include these nurses as it could be possible that moral distress has led to their leaving this practice setting or leaving the profession all together.

The current research and its findings raise other specific questions for future studies:

1. To what extent do formal and informal supports for moral conflict mediate the development of moral distress in non-acute continuing care nurses?

2. What are the strategies used to alleviate moral distress in non-acute continuing care nurses?
3. How have previous experiences of moral distress affected nurses' career decisions in the past or will impact decisions in the future?
4. Do the decisions of individuals in formal leadership roles impact the development of moral distress in non-acute continuing care nurses?
5. What role does nursing experience play in coping with moral conflict and the development of moral distress in non-acute continuing care nurses?

Implications for Nursing Education

The implications of the findings of this study are that nursing students should be introduced to all types of moral-ethical principles and thinking. This would include complex moral dilemmas but also the more common everyday ethical and moral conflicts that nurses' experience that is often termed "everyday ethics". This includes moral norms such as integrity, honesty, faithfulness, and compassion and how these norms are confronted in day-to-day living or work (Hamric, 2000). This will facilitate nurses being able to reason and act in terms of both nursing ethics and personal values and beliefs. An introduction to the concept of moral distress would begin to prepare future nurses for moral conflict in their practice and the potential personal and professional consequences.

The education of nursing administrators either through formal educational programs such as graduate programs or organizationally based programs should include education of the assessment and detection of the experience of moral distress in nurses. As well, nursing

administrators should be prepared in strategies for debriefing staff after distressing events or ongoing debriefing in areas where moral distress occurs frequently.

Implications for Nursing Practice

This qualitative study has identified and validated the presence of moral distress and distressing events in non-acute continuing care nurses that in turn produced moral distress. Recognizing the impact of moral distress on nurses, administrators should focus on strategies and resources to increase moral competence in the workplace and support ethical decision-making. Broadening ethics committee availability to discuss the impact of issues such as available resources, clinical uncertainty, and emotional dissonance may further support nurses in the prevention and resolution of moral distress. An education process for nurses to understand and recognize moral uncertainty, conflict and dilemmas would also facilitate improving nurses' access to and involvement in deliberations related to moral conflicts. Improved communication and collaboration between members of the health care team would also facilitate discussions and ideas for resolving moral conflicts.

Nursing administrators should be prepared to offer and conduct debriefing sessions with staff. The availability of administrators during and after a moral conflict to discuss the professional and personal tolls of morally distressing events may lessen the burden and distress experienced by the nurses involved and provides preventative measures for other staff.

Implications for Nursing Administration

The implications of the findings indicate that less experienced nurses may be at a higher risk of developing moral distress. Nursing administrators should include education for newly hired nurses on the identification on moral distress and mechanisms to support moral

deliberation such as ethical frameworks, and knowledge of ethics committee structures and resources.

The findings also indicated that hierarchical structures are an obstacle to nurses acting on their moral conscience and lead to feelings of powerlessness. Nursing administrators should develop strategies to foster open and effective communication and shared decision-making between all levels in the organizational hierarchy.

A formal mentorship program between novice and experienced nurses may also be effective in preventing moral distress. The findings found that nurses with the most experience encountered less moral distress than more novice nurses. By establishing formal mentor relationships, experienced nurses may be able to provide mechanisms and strategies for managing situations that may have lead to moral distress.

Summary and Conclusions

The moral issues faced by nurses in continuing care settings varied depending on the role of the nurse. Nurses working in a capacity of a nurse manager experienced distress related to team functioning and the day-to-day operations of their organization. Nurses in a clinical role had moral distress involving advocacy for individual patient's needs and rights and indirectly advocating for the patients by advocating for the appropriate use of limited resources.

The experience of moral distress involves initial distress, moral deliberation, obstacles and barriers to moral conscience, and persistent moral distress. Initial distress was experienced when the nurses encountered the moral conflict. The nurses portrayed the experience of initial distress as very intense and emotional, the nurses' experienced negative feelings and thoughts such as anger, frustration and sadness.

Moral deliberation occurred when the nurse encountered an ethical problem; they described a deliberation process that was both formal and informal. Formal processes included taking an issue to a meeting or rounds, and informal deliberation involved acting on personal feelings and intuition.

The nurses described obstacles and barriers to acting on their moral conscience. Perceived and actual barriers such as years of experience, resources and the behaviour of peers lay in the way of nurses acting according to their moral conscience. Nurses described persistent negative thoughts that lingered after the distressing event such as feeling devalued, powerless, disappointed and overall regret.

The nurses described both positive and negative consequences of moral distress. Positive consequences included learning, and changes in practice and approaches to care. Negative consequences of moral distress included peer conflict during and immediately after the moral conflict. Some nurses also described lingering feelings of moral distress that over time have manifested into moral residue. These nurses experience ongoing negative thoughts, feelings, and physical responses such as heart palpitations.

The experience of moral distress in Registered Nurses working in non-acute continuing care is a phenomenon that affects the nurse in a real and significant way. Moral distress occurs after the nurse is faced with a situation involving moral conflict, and because of obstacles or constraints the nurse is not able to act in accordance with their personal or professional values or beliefs. Moral distress is then experienced as an assortment of negative thoughts and feelings in the moment of the moral conflict or that persist after the conflict. Some nurses continue to possess remnants of the negative feelings long after the moral conflict has been resolved, and

these remnants continue to influence nurses' personal and professional lives either in a positive or negative sense.

Two conceptual models were developed in this thesis. The first conceptual model (figure 1) incorporates the findings of the moral distress literature review while the second conceptual model (figure 2) focuses on the findings of this study and the experience of moral distress among non-acute continuing care nurses. Common elements, thoughts, feelings, and steps in the process of moral distress were identified in both models.

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Appendix A

Recruitment Flyer

Research Study

Moral Distress in Non- Acute Continuing Care Settings: the experience of Registered Nurses.

Moral distress involves situations in which nurses cannot fulfill their ethical obligations and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice (Webster & Baylis, 2000).

I am a Master of Science student at Queen's University School of Nursing and I am conducting a study to look at Registered Nurses' experiences of moral distress in non-acute continuing care settings. I will be interviewing nurses who are willing to share experiences from their practice.

If you would like to learn more about this study please contact me.

Tom Hart, RN

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Appendix B

Information Sheet for the Study

The Functioning of Hospital Ethics Committees for Clinical Practice and Nurses' and Physicians' Use of the Committees

Summary of Proposed Study

The Topic

In Canada, hospitals began to establish ethics committees for clinical practice approximately 20 years ago. While hospital ethics committees are in existence in many Canadian hospitals, they may differ in how they function, their reporting structures and decision-making authority, their membership and their mandate. There has been relatively little research in Canada that describes the functioning of hospital ethics committees for clinical practice, particularly in recent years, and it is anticipated that such committees have evolved over time. The purposes of this study are: 1) to describe the functioning of hospital ethics committees for clinical practice and 2) to describe the use of hospital ethics committees by nurses and physicians. The intent is gain insight into how hospital ethics committees function and when and how nurses and physicians may use these committees to manage their ethical conflicts.

The Method

The research is a multiple case study of four Canadian hospital ethics committees. Phase 1 will involve data collection of documents (the terms of reference and minutes of ethics committee meetings), observations of the functioning of the committee meetings, and interviews with key informants. Phase 2 will involve interviews with nurses and physicians who work in the hospitals, but who are not on the ethics committee. Up to two follow-up interviews will be done for verification of data and meanings to ensure accuracy. Triangulation of data sources will also strengthen the trustworthiness of the data. The consent of hospital authorities as well as individuals participating in the study will be sought at the beginning of the study and as required when participants are added in Phase 2.

Documents, observational data and interview transcripts will be entered into a program for qualitative data analysis and data will be analyzed separately for the two phases. Cross-case analysis will be used to look for common themes and meanings across cases.

The Researchers

Dr. Alice Gaudine, Associate Professor, School of Nursing at Memorial University of Newfoundland is the Principal Investigator. Co-investigators are: Dr. Marianne Lamb, Professor, School of Nursing, Queen's University, Dr. Sandra LeFort, Associate Professor, School of Nursing, Memorial University of Newfoundland and Dr. Linda Thorne, Schulich School of Business, York University. Dr. Lamb will be responsible for the Ontario sites and Dr. Gaudine will be responsible for the Atlantic sites.

Study Approvals

This study has been reviewed and funded by the Canadian Institutes of Health Research. Ethics approval has been received from Memorial University's Human Investigation Committee. The proposal has also been approved by the Queen's University Health Sciences Research Ethics Board and PCCC Ethics Review Committee.

For any additional questions, contact:

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July, 2007

Appendix C

Interview Questions

Semi-structured Interview Guide for Nurse Participants

Background variables

- a. Tenure in organization
- b. Position in hospital
- c. Years in current position
- d. Familiarity with hospital code of ethics and functioning of ethics committees
- e. Gender
- f. Age range
- g. Name of employing hospital
- h. Highest level of completed education
- i. Years in the profession

1 (a) Can you think of a situation in which you experienced ethical conflict due to a clinical situation? If yes, please describe.

1 (b) Is this ethical conflict resolved? If so, how did this situation get resolved? If no, why do you feel this situation is not resolved?

1 (c) Is this a situation that be taken to your hospital's ethics committee? Why or why not?

1 (d) With whom did you discuss this ethical conflict? Why?

1 (e) Where did you discuss this ethical conflict? Why?

2 (a) Can you think of a situation in which your values were different from the values of the organization, and this made you experience ethical conflict? If yes, please describe.

2 (b) Is this ethical conflict resolved? If so, how did this conflict get resolved? If no, why do you feel this situation was not resolved?

2 (c) Is this a situation that could be taken to your hospital's ethics committee? Why or why not?

2 (d) With whom did you discuss this ethical conflict? Why?

2 (e) Where did you discuss this ethical conflict? Why?

3 (a) Have you ever taken an issue to the hospital ethics committee? If so, please describe.

3 (b) Do you feel that barriers exist to bringing issues to the hospital ethics committee? If so, please describe.

3 (c) Do you feel that any factors facilitate bringing issues to the hospital ethics committee? If so, please describe.

3 (d) Can you think of an aspect of the hospital that helps to prevent ethical conflict in the workplace, or helps to resolve ethical conflict in the workplace? If yes, please describe.

4. Can you describe a situation in which you have been unable to pursue a course of action or live up to expectations and /or values of your nursing practice
5. Were there obstacles or facilitators in these situations that either helped or prevented you from doing what you believed to be the right thing to do?
6. If you have had a situation where you were unable to act on you expectations or values what were you initial feelings?
7. If there was a time when you were not able to act on your values or what you believed to be the right course of action, were there any feelings that persisted after the situation?

Appendix D

Ethics Approval



December 18, 2006

Dr. Albert Clark
Chair, Health Sciences Research Ethics Board
Queen's University

RE: NURS-177-06

Dear Dr. Clark:

As a follow-up to our telephone conversation, I am writing to request an amendment to the protocol entitled: "The functioning of hospital ethics committees for clinical practice and nurses' and physicians' use of these committees".

Mr. Thomas Hart, a student in the MSc program at the School of Nursing will be conducting his thesis research as part of this larger study. The amendment is the addition of a number of questions regarding moral distress in the interviews of nurses at the non-acute care hospital in the study. I have appended the interview guide for these interviews and a consent form that would be used for the nurse interviews at this hospital as it identifies the topic of Mr. Hart's thesis research and includes him as a contact person.

I am also enclosing a copy of the renewal form in which I identify the amendment for NURS-177-06. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Marianne Lamb
Encl.2



OFFICE OF RESEARCH SERVICES

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January 5, 2007

Dr. Marianne Lamb
School of Nursing
Queen's University

Re: "The functioning of hospital ethics committees for clinical practice and nurses' and physicians' use of these committees" NURS-177-06

Dear Dr. Lamb,

I am writing to acknowledge receipt of your letter dated December 18, 2006 which requested approval for an amendment to the above-named study. I have reviewed this request for inclusion of Mr. Thomas Hart's thesis research as part of this study as well as the accompanying interview guide and consent form and hereby give my approval. This amendment will be reported to the Research Ethics Board.

Yours sincerely,

Albert Clark, Ph.D.
Chair
Research Ethics Board

AFC/kr

think Research
think Queen's

PREPARING LEADERS AND CITIZENS FOR A GLOBAL SOCIETY

Appendix E

Consent

(Consent for nurses who will be interviewed)

CONSENT FORM

Title of Project: The functioning of hospital ethics committees for clinical practice and nurses' and physician's use of these committees.

BACKGROUND INFORMATION

You are invited to participate in a research study examining hospital committees that deal with clinical ethics topics. This study is being conducted in Atlantic Canada and Ontario, by Dr. Alice Gaudine (Principal Investigator) in Atlantic Canada and under the direction of Dr. Marianne Lamb in Ontario. Dr. Marianne Lamb will read through this consent form with you and describe procedures in detail and answer any questions you may have.

This research will also examine moral distress experiences of Registered Nurses practicing in non-acute continuing care settings. This study is being conducted by Thomas Hart to fulfill the requirements for a Master of Science degree at Queen's University School of Nursing. Dr. Marianne Lamb will supervise this graduate work.

DETAILS OF THE STUDY:

The purpose of this study is to examine how hospital ethics committees function and how they may help professionals to resolve ethical conflict. There has been little research on or evaluation of hospital ethics committees. However, there is some evidence that some professionals do not use these committees, although they do have ethical concerns.

If you agree to participate in this study, a researcher will interview you. This interview will take approximately 1 – 1 ½ hours. During this interview, you will be asked to discuss your perception of the hospital ethics committee. You will be asked how this committee, or any other hospital committee, helps you or others to deal with ethical conflict.

With your permission, we will audiotape the interview. A research secretary will then type your interview. Your name will not be written on any transcripts and your identity will be kept confidential. You will be given a copy of this transcript. After you have had a chance to read the transcript, you will again meet with the person who interviewed you. In addition, the researcher may ask for clarification of an issue you discussed. The researcher may ask for a third meeting, if the researcher needs to check information when the data are being analyzed. Meetings will be held at a private location. You are free not to answer any question. Tape recordings will only be available to the research team and will be stored in a locked cabinet.

Your participation in this study is voluntary and there are no identified risks or benefits related to your participation. We will provide a letter at your request however, indicating that you have contributed to an unnamed nursing research project. You may withdraw from this study at any time.

SUBJECT STATEMENT AND SIGNATURE SECTION:

I have read and understand the consent form for this study. I have had the purpose and procedures of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent for my information.

If at any time I have further questions, problems or adverse events, I can contact:

Thomas Hart at 613-389-9741

Dr. Marianne Lamb at 613-533-6000 ext 74764
(Supervisor)

If I have questions regarding my rights as a research subject I can contact:

Dr. Albert Clark at 613-533-6081

Chair, Research Ethics Board

By signing this consent form, I am indicating that I agree to participate in this study.

Signature of Participant Date

Signature of Witness Date

STATEMENT OF INVESTIGATOR

I have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the subject understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

Signature of Principal/Site Investigator Date

