

Moral Distress Experienced by Registered Nurses in Georgia and Its Impact
on Nurse Turnover

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ABSTRACT

Nurses are vulnerable to moral distress because of the inherent moral nature of nursing and because of their position as patient advocates. Previous research suggests moral distress is a reason for nurses leaving their positions and even the profession itself.

This mixed method study examined moral distress experienced by registered nurses (RNs) working in multiple settings of health care in Georgia and its effects on nurse turnover through an anonymous online survey. Hamric's (2010) nurse questionnaire of the *Moral Distress Scale- Revised (MDS-R)* was used to measure the frequency and intensity of clinical situations that result in moral distress. Results revealed that the situation with the highest mean frequency score involved carrying out physicians' orders for what participants perceived as unnecessary tests and treatments. The situation with the highest mean intensity score involved working with levels of nurse or other care provider staffing considered by the participants as unsafe.

An *MDS-R* overall composite score was calculated which measured total moral distress frequency and intensity for each participant. The mean composite score for the sample was 83.00 ($SD = 46.78$). Statistical analysis revealed there was a significant difference in moral distress levels between RNs who left a position or considered leaving a position (but stayed), and RNs who neither considered nor left a position. Thematic analysis was used to analyze participants' responses from the open-ended question on the (*MDS-R*). Among the participants in this study, 27.9% left a position due to moral distress, 31.8% considered quitting but did not leave, and 13.2% are considering leaving their current position because of moral distress with the way patient care is handled at their institution.

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DEDICATION

This thesis is dedicated to all nurses who strive daily to advocate for patients.

Chapter I

INTRODUCTION

Nursing is a profession grounded in ethical standards and moral behavior. Nurses interact with patients more than any other health care professional, which provides a foundation for the development of a unique relationship between nurses and patients and their families (Redman & Fry, 2000). A nurse's primary role is to attend to patients' needs as a patient advocate with this relationship placing nurses in delicate ethical situations (Hardingham, 2004). The practice of nursing can be especially challenging in an environment in which patients' needs might clash with the needs of health care organizations, physicians, families, or other patients (Corley, 2002). Nurses work collaboratively with members of the health care team to provide care for patients and their families, all of whom may have beliefs or values different from their own, making ethical conflicts difficult to avoid (Redman & Fry, 2000). Nurses also experience external workplace constraints. External constraints include inadequate staffing, lack of time, system hierarchies, distressing co-worker relationships, differing professional perspectives, lack of administrative support, policies or priorities that conflict with patient care needs, compromised care due to pressure to reduce costs, and fear of litigation (Hamric, Davis, & Childress, 2006).

The term "moral distress" was first coined by the philosopher, Andrew Jameton. Jameton (1984) discussed the phenomenon of moral distress in his ethics textbook for

nurses. Listening to nurses' stories, Jameton realized that nurses were experiencing stress reactions when they felt unable to take what they believed to be the moral or "right" course of action due to external or internal constraints (Corley, 2002; Nathaniel, 2002). Internal constraints are unique to the person experiencing moral distress and include perceived powerlessness, lack of knowledge, increased moral sensitivity, and lack of understanding the full situation (Hamric et al., 2006).

Wilkinson (1988) further explored the phenomenon of moral distress in nurses and was the first to generate a theoretical model. Corley (2002) developed a more comprehensive theory of moral distress which I selected as the framework for this study. Corley (1995) developed a quantitative instrument to measure the intensity and frequency of moral distress experienced by nurses in clinical practice. The works of Jameton, Wilkinson, and Corley are referenced repeatedly in the literature and they are considered the pioneer experts on the topic of moral distress. Moral distress was first recognized and studied among nurses, though there are studies that document the phenomenon in other professions, including medicine, respiratory therapy, and social work where moral distress was also experienced (Epstein & Delgado, 2010; Hamric & Blackhall, 2007).

Erlen (2001) describes moral distress as a "pervasive problem" in nursing. Studies show that 33 to 80% of nurses report experiencing moral distress in clinical practice (Lerkiatbundit & Borry, 2009). The American Association of Critical Care Nurses (AACN) asserts that "moral distress is a critical but frequently ignored problem in healthcare work environments. Unaddressed, moral distress restricts nurses' abilities to provide optimal patient care and to find job satisfaction" (AACN, 2008, p. 1). The Canadian Nurses Association is concerned enough about the phenomenon that moral

distress is addressed in its 2002 *Code of Ethics of the Canadian Nurses Association* (McCarthy & Deady, 2008).

Many nurses may experience the uncomfortable feelings accompanying moral distress, but are unfamiliar with the phenomenon or the term used to describe it. Nurses may be unaware of the potential consequences of moral distress. In spite of the critical impact of moral distress, the phenomenon is poorly understood by nurses and health care organizations and is rarely acknowledged (Cavaliere, Daly, Dowling, & Montgomery, 2010).

Nurses and other health care providers face more complex ethical issues today than during the early years of exploring the construct of moral distress (Ulrich et al., 2007). Advances in health care technology, nursing shortages, longer life expectancies, fragmented health care systems, health inequities, unequal access to care, a litigious society, and economic strains have all been instrumental in creating more ethical concern in health care.

Statement of the Problem

Moral distress is a serious problem in nursing and has an impact on nurses' job satisfaction, nurse retention and turnover, and on the psychological and physical well-being of nurses (Corley, 2002). Further, moral distress can affect patient care and the fiscal health of health care organizations. Moral distress has been associated with nursing job dissatisfaction and burnout, resulting in some nurses leaving the profession altogether (Cavaliere et al., 2010; Corley, 1995; Corley, Elswick, Gorman, & Clor, 2001; Corley, Minick, Elswick, & Jacobs, 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Wilkinson, 1988; Winland-Brown, Chiarenza & Dobrin, 2010). There is already

a severe nursing shortage in the United States. Any problem that causes nurses to become dissatisfied with their profession to the point of leaving demands the attention of parties with a vested interest in health care now and in the future.

Purpose of the Study

The purpose of this study was to explore the intensity and frequency of moral distress among registered nurses (RNs) working in several different health care settings in Georgia to see if moral distress was a reason nurses left or considered leaving their nursing positions. Prior studies of moral distress focused mainly on nurses working in hospital critical care units such as intensive care, coronary care and emergency rooms. All but one prior study from Florida were conducted in regions other than the southern United States. There was a gap in the literature about whether nurses in non-critical care areas or those practicing outside hospitals experienced the same levels of moral distress and its effect on nurse turnover.

Background and Significance

Registered nurses comprise the largest profession within health care, and health care is the largest industry in the United States (Buerhaus, Staiger, & Auerbach, 2009; Redman & Fry, 2000). Nurses are the primary patient advocates and the central coordinators of the health care delivery team for all patient care services (Redman & Fry, 2000). Nurses develop close relationships with patients that are sometimes at odds with external workplace constraints (Hardingham, 2004).

The Foundation of Nursing. Nursing is considered to be a moral endeavor, a profession grounded in moral and ethical behavior and standards. As far back as Florence Nightingale's day, nurses were called to be moral persons with the virtues of truthfulness,

sobriety, and honesty (Sellman, 1997). Since the year 1999, with the exception of 2001 (when firefighters placed first), nurses have ranked number one in Gallup's annual *Honesty and Ethics Ratings of Professions Survey* (Jones, 2010). Members of society expect that nurses will serve them with an expertise that is unique to the profession (Erlen, 2001).

The American Nurses Association's *Code for Nurses* (2001) guides the relationships of nurses with patients, communities, and the nursing profession (Weis & Schank, 2002). Professional ethics and values are an essential part of nursing education. Students are educated and socialized to maintain those principles in their future nursing practices. Even a strong foundational education in ethics, however, may not prepare nurses to manage ethical situations in everyday practice.

The Challenges of Nursing. Caring for patients is physically, intellectually, and emotionally challenging. Nurses work in stressful environments burdened by worsening working conditions with sicker patients, increased workloads, shortages of nurses, and mandatory overtime--environments where providing safe patient care is challenged (Corley & Minick, 2002). The potential for errors in a complex environment is great. For example, in an urban hospital approximately 20,000 medication orders are written per day (Joint Commission on Accreditation of Healthcare Organizations, 2002). Innovations in health care technology have added to the burden, requiring employment and training of more highly skilled staff. Nursing care is not only focused on meeting physical needs of patients but represents a holistic approach that includes nurturing emotional, psychosocial, and spiritual needs. This results in personal investment by nurses in

relationships with patients, making nurses vulnerable to frustration and distress (Sumner & Townsend-Rocchiccioli, 2003).

Nurse Turnover. Moral distress can lead to job dissatisfaction and turnover. Studies indicate that nurses leave positions and even the profession itself due to moral distress (Cavaliere et al., 2010; Corley, 1995; Corley et al., 2001; Corley et al., 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Wilkinson, 1988; Winland-Brown et al., 2010). When nurses' resources to deal with moral distress are exhausted, job dissatisfaction, burnout, and turnover result (Lerkiatbundit & Borry, 2009). In a study by Aiken et al. (2001) of 43,000 nurses practicing in five countries, 41% of those currently working in the United States reported being dissatisfied with their jobs; 43% of nurses scored high in a range of burnout measures; and 22% were planning to leave their jobs in the next year. Of those intending to leave their jobs, 33% were under the age of 30.

The inability to retain nurses is costly for patients in terms of safety, care quality, and patient outcomes. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states in its white paper, *Healthcare at the Crossroads* (2002), that 24% of the 1,609 sentinel events reported to it (by March 2002) were the direct result of staffing shortages. Sentinel events are unanticipated events that lead to death, injury, or permanent loss of function. As a result of these sentinel events, 386 people died, were injured, or suffered permanent loss of function simply because there were not enough nurses to adequately care for them. Hospitals with nurse turnover rates under 12% rate higher on quality measures, have lower risk-adjusted mortality scores, and have lower

severity-adjusted lengths-of-stay compared to hospitals with nurse turnover rates exceeding 22% (Kosel & Olivo, 2002).

Nurse turnover is costly for health care organizations in terms of operational costs, profitability, productivity, and efficiency. Nurse turnover ultimately affects quality of service and accreditation. A report by the Voluntary Hospitals of America (VHA) determined that hospitals with turnover rates exceeding 21% had a 36% higher cost per patient stay than hospitals with turnover rates less than 12% (Kosel & Olivo, 2002). Turnover rates for hospital RNs are higher than for other allied health professionals and range from 18-26% (Hart, 2005). The financial impact on health care organizations to replace a medical-surgical nurse is estimated to be more than \$92,000 and for a specialty nurse, \$145,000 (Cavaliere et al., 2010). Every percentage point increase in nurse turnover costs an average hospital about \$300,000 annually. Hospitals that perform poorly in nurse retention spend, on average, \$3.6 million more than those with high retention rates (PricewaterhouseCoopers' Health Research Institute, 2007, p. 4). Adverse patient outcomes and reduced quality of care can directly affect an institution's reputation and jeopardize its ability to meet accreditation standards.

Future Demand for Health Care Services. Increased demand for health care services in the United States will increase the demand for nurses. Some of the factors influencing the demand for health care services are changes in the health, size, age, and composition of the population (Buerhaus et al., 2009). Researchers project that the U.S. population will reach 336 million by 2020 and 420 million by 2050 (p. 59). The proportion of elderly people in the total U.S. population is increasing steadily. Those born in the baby boom generation (1946 to 1964) will become part of the senior population in

2010 and are projected to live longer because of advancements in medical technologies. By the year 2030, one in five Americans will be over the age of 65 (p. 61). Aging populations suffer more chronic, degenerative illnesses which require more care. The Patient Protection and Affordable Care Act passed in 2010 will give access to health care services to 32 million more people in the U.S. which further increases the need for health care providers.

Nursing Shortages. The projected growth in demand for RNs is 2-3% annually. The projected shortage of RNs is expected to reach 500,000 full-time-equivalent RNs by the year 2025 (Buerhaus et al., 2009). Because RNs have more direct contact with patients than other health care providers, they are more important in early detection and timely treatment when patients' conditions change or deteriorate. Since nursing is the largest component of the health care work force, shortages of RNs have a significant impact on health care delivered to patients.

A rapidly aging workforce is a primary contributor to the projected nursing shortage. From 2002 to 2006, the largest employment growth in nursing occurred in the 50-64 age group. The average age of the full-time RN in 2006 was estimated to be 43.7 years. By 2012, the average age of this group will reach 44.5 years and RNs in their 50s will account for the largest group. Their expected retirement over the next decade will lead to a projected cataclysmic decline in working RNs by 2019 (Buerhaus et al., 2009).

Another factor contributing to the current nursing shortage is the smaller number of students entering nursing programs. According to the American Association of Colleges of Nursing's (2010) press release on the *2009-2010 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing* survey, 54,991

qualified applicants were turned away from baccalaureate and graduate nursing programs in the U.S. in 2009. Lack of faculty (61.4%), insufficient clinical teaching sites (60.8%), limited classroom space (47.5%), budget cuts (32.2%), and insufficient preceptors (31.0%) were cited by nursing schools as the major reasons for turning students away (American Association of Colleges of Nursing, 2010).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2002) asserts that attraction to nursing as a career has been weakened by staffing and scheduling problems, excessive workloads, and organizational cultures perceived as not valuing, empowering, or rewarding nurses. In the American Nurses Association (ANA)'s survey on staffing (2001) over 54% of nurse respondents would not recommend their profession to their children or their friends.

Although there have been nursing shortages in the past, the current shortage of nurses in the United States has been longer lasting and is expected to continue despite the surge in health care jobs during the current recession. The aging nursing workforce, women's expanded employment options, the stigma men face when entering a nontraditional career field, and unrealistic workloads are barriers to achieving an adequate supply of RNs.

Studies have found that nurse satisfaction, and ultimately intent to remain in a job is increased when nurses practice in what they perceive as an ethical environment (Corley et al., 2005; Hart, 2005; Pauly, Varcoe, Storch, & Newton, 2009; Ulrich et al., 2007). The projected increase in demand for nurses makes it imperative for nurse and health care administrators to create ethical cultures that support workplace retention.

Research Questions

Moral distress and its impact on nurse turnover required study to determine if nurses in Georgia working in both critical and non-critical care settings are experiencing moral distress and if so, how much and how often. Research was needed to see if nurses in Georgia left nursing positions due to moral distress. Accordingly, this study addressed the following research questions:

1. What clinical situations of moral distress are experienced most frequently among RNs working in health care in Georgia?
2. What clinical situations lead to the highest intensity of moral distress among RNs working in health care in Georgia?
3. What is the composite level of moral distress among RNs working in health care in Georgia?
4. What is the prevalence of nurse turnover or intent to turnover due to moral distress among RNs working in health care in Georgia?
5. Is there a difference in moral distress among RNs who: (a) left a position, (b) considered leaving a position, and (c) neither considered nor left a position?

Delineation of Variables

In this study moral distress was the independent variable and intent to turnover or leave was the dependent variable. The intensity and frequency of moral distress experienced by nurses was measured by participants' ratings of the frequency and intensity of clinical situations on the nurse questionnaire of the *Moral Distress Scale-Revised (MDS-R)* (Hamric, 2010). Those ratings were used to calculate a composite moral distress score resulting in one measure for the level of moral distress. The prevalence of nurse turnover

due to moral distress was measured by participants' responses to questions asking whether they had considered leaving or left a position due to moral distress.

Definitions of Terms

The definitions of terms used for the purposes of this study were:

Registered Nurse (RN) - a person who graduates from an accredited school of nursing and is registered and licensed to practice by a state authority.

Morals - principles of right and wrong behavior.

Values- enduring ideals or belief systems to which a person or a society is committed.

Values represent the basic convictions of what is right, good, or desirable, and motivate both social and professional behavior.

Ethics - standards of conduct and moral judgment of a profession.

Moral distress - painful feelings and/or psychological disequilibrium that occurs in situations in which the ethically right course of action is known but cannot be acted upon due to internal or external constraints. As a result, persons with moral distress act in a manner contrary to their personal and professional values which undermines their integrity and authenticity.

Moral residue - the lingering feelings after a morally problematic situation has passed.

Turnover - employee withdrawal from a position or from the workplace.

Theoretical Framework

Corley's theory of nurse moral distress (see Figure 1) provided a framework for this study. Corley cites the early work of Jameton (1984) in defining moral distress and proposes her theory is designed to "clarify what happens when a nurse is unable or feels

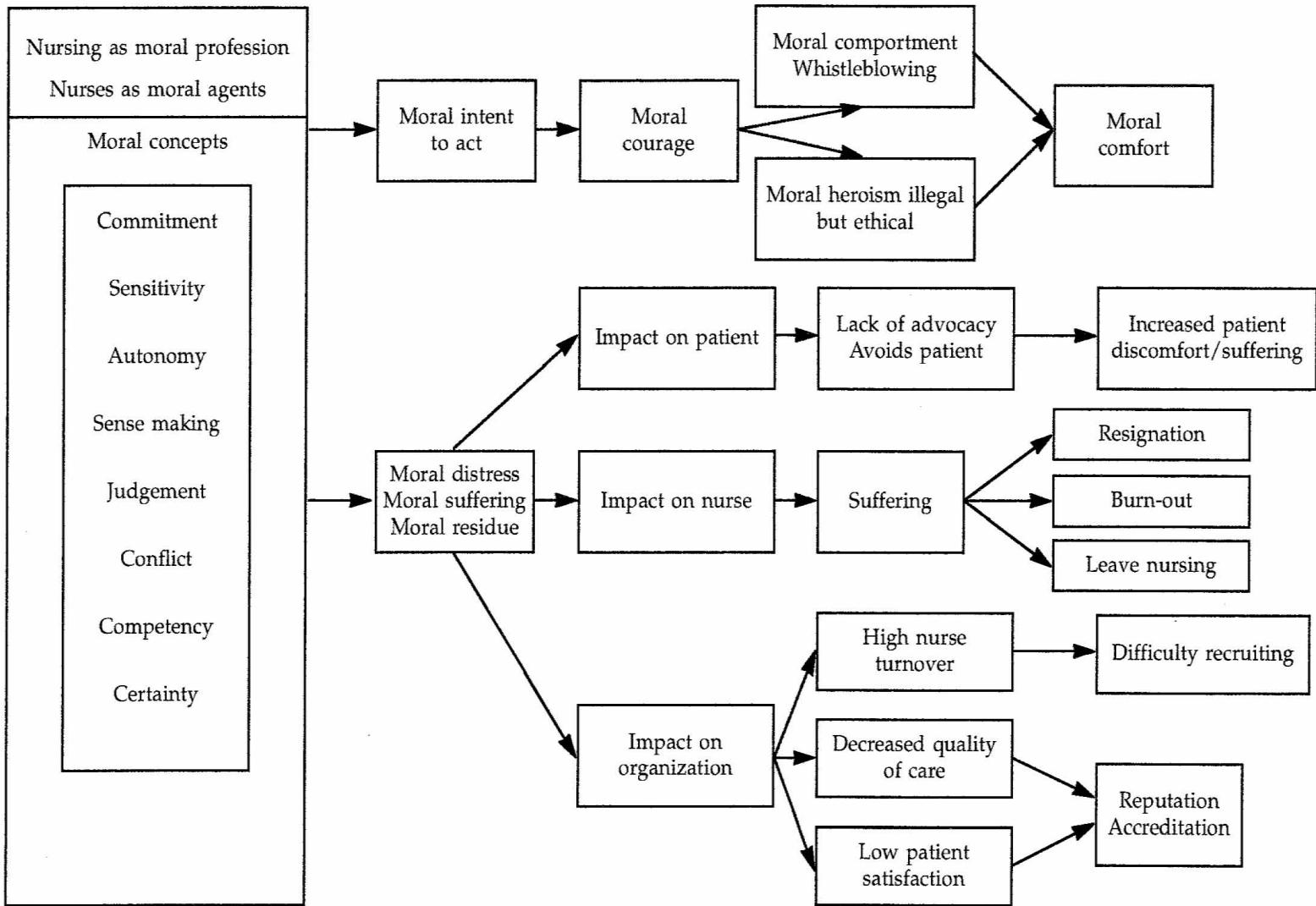


Figure 1 Model for a theory of moral distress

Figure 1. Model for a Theory of Moral Distress. From: Corley, M. (2002). Nurse moral distress: a proposed theory and research agenda. *Nursing Ethics*, 9 (6), p. 645.

unable to advocate for a patient” (Corley, 2002, p. 643). Corley’s theory suggests a relationship among moral distress, nurse satisfaction, burnout, and nurse attrition.

Moral integrity is defined as “adherence to moral values affecting the sense of dignity and self-respect” (Corley, 2002, p. 645). Corley maintains that it is the inability of nurses to act according to their moral convictions and, thus, preserve their moral integrity, which leads to moral distress. She also says that when “nurses have compromised themselves, or allowed themselves to be compromised” they might carry “moral residue” as a result (p. 645). Moral residue means persons carry the experience with them throughout their nursing careers. To avoid the consequence of moral residue, developing moral competence would lead the nurse to moral comfort.

Corley’s theory (2002) lists the interrelated moral concepts important in explaining nurses’ vulnerability to moral distress and in the development of moral competence (moral behavior). Corley first identifies moral concepts that nurses embody as part of their development as moral agents. These central moral concepts that interact are commitment, sensitivity, competency, sense making, autonomy, certainty, judgment, and conflict. If nurses in their workplaces are easily able to adhere to these basic moral concepts, they will maintain their moral integrity and experience moral comfort. If they cannot adhere to these moral concepts in their workplace, moral distress will result.

Commitment. Moral commitment is instrumental in the development of moral competency, enabling nurses to engage in moral practice and, as a result, experience less moral distress (Corley, 2002). Nurses are committed to their patients. Moral commitment

is defined as “engagement with a moral issue in patient care, loyalty to the values involved, and a willingness to take risks” (Corley, 2002, p. 645).

Sensitivity. Moral sensitivity is defined as “the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient’s vulnerable situation, and have insight into the ethical consequences of decisions made on behalf of the person” (Lützén, Johansson, & Nordström, 2000, p. 21). Moral sensitivity is important as “an affective component in the process of ethical decision-making” (Lützén et al., p. 21). The development of moral sensitivity can be influenced by a strong role model, ethics education, gender, education, and experience. Moral distress can be moderated by the presence or absence of moral sensitivity. Moral sensitivity positively affects development of moral competency and ability to manage moral distress (Corley, 2002). A lack of moral sensitivity can be caused by situations which “psychologically wound” nurses and cause them to “lose their caring ability.” If moral sensitivity is lost, nurses may become immune to experiencing moral distress (Corley, 2002, p. 645).

Autonomy. Moral autonomy is defined as “the freedom, right, and responsibility to make choices” (Corley, 2002, p. 646). Lack of moral autonomy can lead to moral distress unless a nurse possesses the other central moral concepts, such as commitment and competence (Corley, 2002).

Sense Making. Moral sense making is “the structuring of moral meaning” (Corley, 2002, p. 646). This structuring interplays and is positively influenced by high levels of moral commitment and moral competence. The combination of these characteristics plus the ability of the nurse to “make sense of a situation” means she or he will experience less moral distress (p. 646).

Judgment. Moral judgment “involves integrating numerous ethical considerations that count for or against a particular course of action in order to determine what ought to be done in a specific situation” (Corley, 2002, p. 646). In moral decision-making, “moral imagination” is important in defining the moral options for consideration (p. 646). Moral judgment by nurses is enhanced by high levels of moral commitment, moral imagination, moral competency, and moral sense making (Corley, 2002).

Conflict. Moral conflict is “a situation involving a clash of moral values concerning what is the morally right action to take” (Corley, 2002, p. 646). Moral conflict will be experienced by nurses if they, in their role as advocate for a patient who is suffering, feel they have a right to take action or they perceive that their values are being violated and they have limited choices (Corley, 2002).

Competency. Moral competency is defined as “the ability to make moral sense of situations, and use good moral judgment and intention, and engage in morally appropriate behavior” (Corley, 2002, p. 646). Moral competency is integral in preventing moral distress. Nurses who have failed to accurately evaluate their own levels of moral competence risk “morally inappropriate actions” (p. 646).

Certainty. Moral certainty is defined as “a feeling of absolute conviction that leads nurses to risk self, personally and professionally, to act on the ‘rightness’ of that conviction” (Corley, 2002, p. 646). Moral certainty is increased when there are high levels of moral commitment, moral competence, and moral autonomy and leads to less moral distress (Corley, 2002).

Interplay of the Moral Concepts in Nursing Practice. Nurses confront both subtle and dramatic ethical pressures in their everyday nursing practice. It is the relationship

among the eight complex interactive concepts that gives nurses moral agency, and all are needed. The interplay among the moral concepts can either lead to the intent to act in an ethical situation (as in the situation below) or cause nurses to suffer from moral distress (Corley, 2002).

"So we stepped outside the room, and then he [physician] was furious with me for not being supportive of him. Because several times she [patient] looked to me, because I've been with her, and she was looking for some support. Her husband was trying to say it, but he wanted her to live at any cost. So when somebody offers a ray of hope, then why wouldn't you go for it? He [husband] was doing it out of love. And he [physician] told me that I was just the nurse and who did I think I was saying things when he is trying to tell the patient what is going on. And I said, 'Well, I'm a patient advocate, and what the patient is telling me is she is not in agreement with what you say'. And then he said I work for the hospital and I work for him. And I said, 'No, I don't; I work for the patient.' And so I think I am very protective of my patients as if they were my own children. Because sometimes we are the only thing as nurses that stand between something that can be good for them or something that can be bad for them." (Robichaux & Clark, 2006, p. 484)

A moral intent to act is defined as "weighing the priority of (central) moral values over personal values to do what is right" (Corley, 2002, p. 646). Initially, moral outrage (anger and shock) occurs in response to a moral situation. Moral outrage alone will not result in a nurse taking a stand on an ethical issue. Nurses must have the autonomy and

moral courage to speak out. Moral courage is the “willingness to take a controversial stand or one that challenges the health care organization or those in it, even when a person’s job may be jeopardized” (Corley, 2002, p. 647). Liberty and courage to take action will provide nurses who experience moral outrage with a defense against moral distress (Corley, 2002).

Moral agency (behavior) is also known as ethical comportment. Corley (2002) subscribes to Benner's (1991) definition of ethical comportment as “the embodied or skilled know-how of relating to others in ways that are respectful and support their concerns” (p. 2). Comportment involves more than words, intents, beliefs, and values. It also includes stance, touch, orientation, and action. Moral commitment and advocacy for patients, combined with moral imagination, sensitivity, the ability to make sense of moral situations, the ability to function autonomously, and moral intention lead to moral certainty. Moral certainty will enable nurses to become competent in moral decision-making, and thus take the morally appropriate action. This path to moral action leads to moral comfort for the nurse (Corley, 2002).

Moral comfort is defined as “an individual’s feeling of ease about a decision related to ethical problems” (Corley & Minick, 2002, p. 8). Nurses who feel that they are able to make decisions “in the best interests of the patient” have input into decisions for the patient’s care plan, and are able to “alleviate or reduce the patient’s pain and suffering” experience moral comfort (Corley & Minick, 2002, p. 8).

The intent to act, which requires moral courage, may take the form of moral comportment (behavior) or whistle-blowing, or rule bending to advocate for the patient. This ultimately provides moral comfort for the nurse. Conversely, if the nurse is unable to

take moral action, moral distress occurs (Corley, 2002). The relationships among these concepts are illustrated in Figure 1.

Corley's theory includes institutional constraints as one impetus for development of moral distress. Such institutional constraints may include insufficient staffing, incompetent staff, and organizational policies or procedures. If these constraints prevent nurses from providing patient care in accordance with nursing's goals, then moral distress ensues. Corley (2002) identifies the professional goals of nursing as protecting patients from harm, providing safe and quality care, and providing a "healing psychological environment for patients and families" (p. 637).

Moral distress negatively affects patients, nurses, and the health care organization (Corley, 2002). The effects of moral distress on patients include increased patient discomfort or suffering as a result of a lack of advocacy by nurses. Lack of advocacy may even take the form of avoiding patients. Other effects on patients include increased pain, extended length of hospital stay, or inadequate care. Corley says moral distress causes suffering for nurses and leads to burnout and leaving positions or the nursing profession. She states that the spiraling effects of moral distress on health care organizations are high nurse turnover resulting in difficulty recruiting, decreased quality of care, and low patient satisfaction. These effects jeopardize reputation and accreditation.

Assumptions

This study was based on the following assumptions:

1. Participants completing the survey were Georgia RNs.
2. Nurses answered the survey questions honestly regarding moral distress.

3. The nurse questionnaire of the *Moral Distress Scale-Revised (MDS-R)* is a valid and reliable instrument for measuring moral distress and nurse turnover due to moral distress.

Limitations

Limitations of this study include:

1. The use of a convenience sample of volunteer RNs in Georgia for the study limits generalization of the findings.
2. There may be response bias. Those who were experiencing either a large amount or a minimal amount of moral distress may have been more likely to respond.
3. The responses could potentially have been deliberately distorted because of the use of a self-report survey.
4. Since participation was anonymous and the survey was offered via the Internet, there was no way to confirm that the participants were RNs working in health care in Georgia.
5. Since the survey was only offered online, those who did not have access to a computer or who were not computer literate would have been excluded from participating in the study.
6. The study employed the nurse questionnaire of the recently developed *Moral Distress Scale-Revised (MDS-R)* as the survey instrument. There is insufficient psychometric data at present to document its reliability and validity.

7. There was no theoretical or conceptual definition of what the composite moral distress scores mean in terms of relative distress found in the literature and the information was not available from the developer of the instrument.

Summary

Nurses are vulnerable to moral distress because of the inherent moral nature of their profession and because of their positions as patient advocates. Nurses might experience moral distress in practice, but may not be familiar with the phenomenon which describes their experiences and resulting feelings. Furthermore, they may not realize there are resources to deal with moral distress before it becomes a destructive force personally and affects their job satisfaction negatively. This study may provide nurses and health care administrators with an understanding of moral distress so they can strategize to reduce its occurrence and its negative effects.

Chapter II

REVIEW OF LITERATURE

The literature identifies moral distress as a major problem in the nursing profession. This chapter addresses the relevant literature about moral distress and its association with nursing turnover. The major areas of review are ethical foundations of nursing, moral distress, and nurse satisfaction and retention.

Ethical Foundations of Nursing

It is critical to examine nursing's strong ethical foundations to understand moral distress in nursing. Nursing is guided by ethical principles such as beneficence, non-maleficence, and autonomy (American Nurses Association, 2001). Beneficence is defined as actions taken to benefit a person and non-maleficence means "do no harm." The principle of autonomy includes respecting a patient's right to make informed decisions without interference. These are examples of basic ethical principles that are incorporated into nursing education curricula.

The definitions for the term "morals" and the term "ethics" are sometimes used interchangeably. For purposes of this study, Jameton's (1984) definitions will be applied. Jameton defines "morals" as "a set of values or principles to which one is personally committed" (p. 5). An example is treating others as one wishes to be treated. On the other hand, "ethics" are the "publically stated and formal sets of rules or values," such as those

in the American Nurses Association's *Code of Ethics for Nurses* (p. 4). "Morals" refer more to the personal and "ethics" more to the professional, societal aspects.

Historically, nurses have focused on the humanistic "ethic of caring." Today, the nursing professional ethic of caring is more complex. Standards of care change rapidly with the advances in technology extending medical potential. One example is how technology allows for maintenance of life even when the quality of that life is severely compromised. These societal transformations have added to ethical complexity in health care.

Professional values such as altruism, dignity, integrity, and social justice are an integral part of nursing education. The American Association of Colleges of Nursing (AACN) identifies and defines professional values for implementation in curricula for those institutions it accredits. Nursing education stresses leadership roles and provides students with practice identifying values conflicts. Educators attempt to engage nursing students by posing case studies that require serious ethical reflection. Leading nurse educators are cognizant of the fact that ethical decision-making skills are necessary to traverse the obstacle course of ethics conflicts that can occur in today's complex health care environment.

Ethical guides for nurses are traditionally encoded in documents such as the American Nurses Association's *Code of Ethics for Nurses*. The ANA code addresses concepts such as human dignity, patient advocacy, professional accountability, autonomy, integrity, collaboration, and social reform. In addition to the ANA code, the International Council of Nurses (ICN) has established an international code of ethics for nurses (Leners, Roehrs, & Piccone, 2006). The ANA *Code of Ethics for Nurses* and

nurses' professional values are discussed in the following sections to demonstrate their influence on nursing practices.

Code of Ethics for Nurses. The document embodying the public statement of nursing ethics is written by expert members of the ANA. The 2001 ANA *Code of Ethics for Nurses with Interpretive Statements* (ANA Code) offers ethical and legal guidance for nurses. It provides nurses, patients, and the general public with information on the core values of nursing (Lachman, 2009). The ANA Code provides a “social contract” with those who are served by the nursing profession (Lachman, 2009, p. 55) and is a standard of measurement for nursing practice (Hook & White, n.d.). It is a valuable document for nurses in today's health care environment because situations occur regularly in which nurses participate in ethical decision-making.

The latest ANA Code (2001) describes the nursing profession's commitment to provide exceptional care to patients and communities, and to support fellow nurses in the process. The goal is for nurses to fulfill their ethical obligations and simultaneously meet their own professional goals.

The ANA *Code* consists of nine provisions. Provisions One, Two, and Three detail fundamental values of the professional nurse in caring for patients and their families. These values include nurses' respect for human dignity, nurses' primary commitment to the patient, and nurses' protection of patient privacy. Provisions Four, Five, and Six discuss duty and loyalty, and deal with ethical applications of respect for persons and self. In addition, this section describes how nurses create ethical work environments. Provisions Seven, Eight, and Nine expand nurses' duties beyond direct patient care. They include provisions to advance the profession of nursing by knowledge

expansion, participation in professional associations, and collaborating with other health professionals in addressing issues which concern public health needs (Hook & White, n.d.).

Nurses as Moral Agents. Corley's (2002) theory emphasizes the idea that nurses are moral agents. Research about nursing values and ethical decision-making illuminates how intricate a process moral decision-making can be. Student nurses are taught the principles of the ANA Code in their nursing courses. The ANA Code is the major document that serves as a guide for nurses, but perhaps more influential is the socialization into the profession that students receive during the nursing education process and in their initial career positions. Leners et al. (2006) attempted to track and measure student learning of professional values in a Bachelor's degree nursing program in the western U.S. The authors were able to demonstrate that the sample of 128 students' professional values changed significantly from the time they entered the nursing program until they finished. Leners et al. state, "nursing values are internalized through professional socialization—the process of learning or understanding the 'nature of being' a nurse" (p. 505).

Rassin (2008) found that basic professional values for the nursing profession have not changed since Nightingale's time. Human dignity, equality among patients, and prevention of suffering ranked highest among the list of 20 professional values with 323 Israeli nurses who were practicing in varied settings and roles. The top ranked professional values were concerned with nurses' responsibilities toward individual patients. However, Rassin was concerned that responsibility towards one's profession and society (social commitment) was less valued than in earlier studies. Rassin wondered if

that might represent trends toward individualism and narcissism in our current society. For example, the values of public health and research were ranked last on the list of professional values. The personal values of honesty, responsibility, and intelligence were rated highest. It is interesting that there were no major differences in professional values between male and female nurses. As for personal values, the more educated nurses, as well as those in administrative positions, valued independence more highly than did the less educated or staff nurses. Value differences may affect nurses' satisfaction with practice. For example, facing institutional constraints may be especially distressing for those nurses who highly value independence.

Weis and Schank (2000) developed and tested a 44-item Likert scale survey specifically to test professional values in the 1985 ANA *Code of Ethics for Nurses*. The instrument was divided into 11 subscales based on value statements within the code. Weis and Schank were able to demonstrate high reliability and validity for their *Nursing Professional Values Scale* instrument and articulate its usefulness as a research, educational, and administrative tool.

LeDuc and Kotzer (2009) used the *Nursing Professional Values Scale* to compare the professional nursing values of 97 junior and senior students, 46 new graduates, and 84 seasoned professionals. Participants' ages ranged from 20 to 52 years. Results revealed no statistically significant differences between the responses of the three groups to each of the 11 *Nursing Professional Values Scale* subscale categories. The groups' responses were highly congruent. Researchers found no intergenerational differences in values, nor did they find experience as an RN to be necessary before nursing professional values were developed. There was no evidence of any gap between education and practice.

Fagermoen (1997) conducted a two-part qualitative study that explored the values that underlie nurses' identities and what nurses find meaningful in their work.

Professional identity encompasses how nurses internalize their nursing values into a personal philosophy of nursing. This personal philosophy is expressed in nurses' thinking, actions, and interactions. Nurses in the study reported the overall moral philosophy of their practice as "altruism" and their core value as "human dignity." The Oxford English Dictionary defines altruism as "devotion to the welfare of others, regard for others, as a principle of action; opposed to egoism or selfishness." Values the nurses linked with human dignity in Fagermoen's study included personhood (treating persons as individuals); being in communion with others; developing reciprocal trust; treating persons with integrity (viewing the patient as having a past, present, and future and as needing security and hope); providing privacy; and protecting autonomy.

Jensen and Lidell (2009) examined nursing values by looking at the influence of conscience and its effect on nursing care. Jensen and Lidell describe conscience as an individual's moral perspective which is formed by ideals and societal norms, and which is governed by external or internal forces. The nurses' responses led the researchers to conclude that conscience is an important factor in "exercising their profession" (p. 31), especially with decision-making. Three descriptions of the role of conscience in nursing emerged from the interviews: conscience as a driving force moving nurses to act with courage and give patient-centered, high-quality care; conscience as a restricting factor giving nurses an awareness of inadequacies in care; and conscience as a source of sensitivity to the vulnerability of patients who need an advocate in order to have their needs met.

The nurses in Jensen and Lidell's (2009) study stated that it was their duty to provide high quality care and place the patients' needs above their own. They identified the importance of acting with moral courage, whether in talking with patients about difficult issues, or with questioning physicians regarding treatment that made them uncomfortable. The nurses gave conscience as the reason for implementing measures they felt would benefit patients regardless of their prognoses, and reported being guided by their conscience about what was the right or wrong action. Theoretically, if they were blocked from advocating for their patients or from providing high quality care, the nurses might well encounter moral distress.

Nurses' moral values appear to be consistent whether they are studied in the United States, Europe, or the Middle East. Lindh, Severinsson, and Berg (2007) examined Swedish student nurses' views on moral responsibility in nursing practice using written narratives. Analysis revealed the main theme of moral responsibility in nursing was to possess a "relational way of being" which was an outcome of two themes: being guided by one's inner compass and striving to do "good" (p. 133). To be guided by one's inner compass means that a nurse continually conducts ethical self-assessments. Nurses reflect on their own actions to see if they are congruent with their own ideals. Striving to do "good" involves practice that is reflective of one's value to respond to the suffering and needs of patients.

The reviewed studies in this section related to nursing values reveal that nurses share a core philosophy when it comes to nursing professional values. These values are consistent with the ANA Code and the ICN Code. Nurses agree that nursing is by its nature a moral profession based on its patient-centered orientation. The reviewed studies

demonstrate how central that ethical responsibilities are to practicing nurses. When nurses are unable to practice according to their professional and personal ethics, they are at risk for developing moral distress.

Reality of Implementing Nursing Values in Practice. Health care takes place in a complex environment with the competing needs of patients, families, staff, and health care organizations for nurses to consider when caring for patients. When nurses enter practice, they may find they cannot practice according to their professional values due to constraints they encounter in the workplace. For instance, the nurse's position as primary patient advocate can place them in conflict with physicians, institutions, and patients' families. Studies reviewed in this section show that dealing with these constraints is a source of job dissatisfaction for nurses.

Beagan and Ells (2009) conducted qualitative interviews with Canadian nurses to explore their key nursing values and to see if these values were supported in daily practice. The key values identified were helping others, caring and compassion, making a difference, patient-centeredness, advocacy, professional integrity, holistic care, and sharing knowledge for patient empowerment. Nurses in the study revealed numerous challenges and frustrations. The inability to make a difference, sustain patient-centeredness, and conflicts between the values of patients and those of colleagues were described frequently in the interviews. Participants cited burnout and detachment from patients as consequences of these frustrations. Many of the nurses became "profoundly disillusioned when they found they were unable to do what they entered nursing to do" (p. 94).

Maben, Latter, and Clark (2007) examined new nurses' experiences with implementing their ideals and values in their nursing practices. They conducted a qualitative longitudinal study with newly licensed nurses in the United Kingdom. Student nurses, in the last week of their nursing program, were asked about their values and ideals for nursing practice and the approach they planned to adopt. After 11-15 months post-qualification, nurses were asked to describe their current practice and compare it with their vision for their practice that they had as students.

Only four of the 26 nurses in Maben et al.'s (2007) study described success with being able to maintain their ideals in their practice. Two of those four nurses changed nursing positions in order to accommodate their ideals. Fourteen of the nurses were categorized as "compromised idealists" because they felt frustrated by only being able to partially implement their ideals in practice. Eight of the participants, within two years of practice, became what the researchers categorized as "crushed idealists" in trying to maintain their values in the practice of nursing (p. 99). Those were the nurses who most often contemplated leaving the nursing profession altogether.

Maben et al. (2007) found that the majority of participants ultimately experienced frustration and emotional exhaustion. The inability to maintain their professional values led to disenchantment with the profession, frequent changes in jobs (attempting to find a more suitable environment), or making the decision to leave the profession altogether. Organizational constraints in the work environment emerged as the main obstacle they viewed as compromising their values.

Millette (1994) conducted a qualitative study of moral decision-making processes used by 24 nurses in Western Massachusetts. The nurses reported an "inability to act on

their convictions” and “inability to provide care that was within the best interest of the patient” (p. 670). Their stories related events in which the nurse felt powerless or abandoned when faced with conflicts with supervisors, physicians or the employing organization. Half of the nurses in Millette’s study described leaving their positions or the nursing profession because of this. Powerlessness is a theme common in the narratives of nurses suffering from moral distress.

Enns and Gregory (2007) interviewed surgical unit registered nurses to examine narratives of caring from surgical nurses’ perspectives. The most significant theme from the narratives was “lamentation and loss,” with participants experiencing a sense of loss at being unable to provide the kind of care they wished to give. This theme was undergirded by constraints identified in the workplace environment such as lack of time, increased patient acuity, lack of continuity of care, and health care personnel not caring for each other. The workplace constraints the nurses encountered interfered with their care giving potential.

Torjuul and Sorlie (2006) conducted a phenomenological-hermeneutic study with surgical nurses in Norway to determine the kinds of ethical situations nurses face in surgical units. The researchers asked the nurses to describe one or more ethically difficult situations they encountered in practice and their feelings associated with the experiences.

Torjuul and Sorlie (2006) found that nurses experienced difficulty in situations in which they were not allowed to be open and honest with patients and families. Nurses also reported conflict in situations in which they had differences of opinion with the physicians concerning withdrawing or withholding treatment and with providing holistic care. Finally, nurses had trouble with institutional constraints, such as heavy workloads

and lack of time, which lessened the quality of care they were able to deliver. They were not satisfied if they could not give care that was up to their personal standards. Nurses were also troubled by what they perceived as ineffective protection of patients' rights to privacy and confidentiality.

Kelly (1998) used a grounded theory approach to examine nurses' processes of adapting to their ethical roles in clinical practice. Kelly interviewed nurses who were two years post-graduation and asked what they perceived as major influences on their moral values related to their clinical roles. The core basic psychosocial process for the nurses was learning how to preserve their moral integrity. Kelly found that when nurses' moral integrity was compromised it meant the whole self and identity of the nurse was also threatened. The new graduates described experiencing moral distress at being unable to fulfill their moral obligations to patients. They voiced disappointment at not becoming the nurses they had anticipated they would be. Ultimately, the new nurses' moral expectations for their clinical nursing practice were not met.

Nurses are in the role of primary patient advocate and assume responsibility to protect the patient who is vulnerable. Studies reviewed in this section illustrate that nurses experience moral distress when they cannot practice according to their professional values.

Moral Distress

According to Corley's theory the inability to practice nursing according to one's professional values is an antecedent to the development of moral distress. When nurses' practices are incongruent with their personal values and identity, their personal moral

integrity is compromised. Moral integrity is defined as “adherence to moral values affecting the sense of dignity and self-respect” (Corley, 2002).

Description of Moral Distress. Although nurses and other health care providers experience moral distress in practice, many are not familiar with the term. However, moral distress has been a phenomenon discussed in the literature since the philosopher, Andrew Jameton, first gave it a name over 25 years ago.

Jameton (1984) conceived the term “moral distress” based on descriptions by nurses of their experiences and feelings regarding ethical issues. Jameton differentiated between moral distress and moral dilemma. He described a moral dilemma as a situation in which there are two actions, both ethical, which could be taken. In the case of moral distress, there is only one ethical action to take. Jameton realized that nurses he observed were not describing moral dilemmas. The nurses were not conflicted on an action to take; they knew which “right” or ethical action was appropriate to the situation. Yet they felt powerless to take that action. The nurses were unsure what to do about the institutional obstacles and repercussions from others in taking that “right” action. Hence, Jameton maintained that “moral distress arises 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).

Jameton (1993) further distinguished two types of distress experienced by nurses as initial and reactive. Jameton says initial distress involves the feelings (anxiety, anger, and frustration) nurses feel when there are conflicts with institutions and others concerning moral issues. Jameton defines reactive distress as the distress nurses feel when they do not act on their initial distress.

Fry, Harvey, Hurley, and Foley (2002) examined whether Jameton's (1984) phases of "initial moral distress" and "reactive moral distress" were relevant to military nurses' experiences. Fry et al. developed a model of moral distress that would relate to crisis nursing during military deployment. The researchers conducted open-ended interviews with 13 U.S. Army Nurse Corps officers concerning their moral distress experiences. Fry et al. (2002) found that crisis military deployment offers a unique contextual setting fraught with moral distress situations. The researchers noted dimensions of the moral distress experience, particularly of reactive moral distress, that hadn't been described previously. Fry et al. developed a theoretical model to illustrate how moral distress could be uniquely applied to the military nursing context.

Since Jameton (1993) first described the phenomenon of moral distress, the definition of moral distress has been clarified and expanded in the literature. Wilkinson (1988) defined moral distress as "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (p. 16). Wilkinson's (1988) model indicated that moral distress encompassed both the experience (moral situation, constraints, and feelings of powerlessness) and the effect (exhaustion of nurses' coping reserves and influence on patient care).

Corley (2002) defines moral distress as "a consequence of the effort to preserve moral integrity when persons act against their moral convictions" (p. 645). Pendry (2007) broadens the scope of constraints to both internal (resulting from the nurses' belief systems) and external (within the workplace environment) constraints. Pendry defines moral distress as "physical or emotional suffering that is experienced when constraints

(internal or external) prevent one from following the course of action that one believes is right” (p. 217).

Hamric (2000) extended Jameton’s concept of moral distress to include those who feel distress because they perceive that the information they have about the appropriate ethical action to take is insufficient. Hamric, Davis, and Childress (2006) also support Jameton’s premise that moral distress is different from moral uncertainty, a situation in which the clinician does not know the ethically correct course to pursue.

Fry et al. (2002) describe moral distress as occurring when “a person who has a responsibility for moral action, experiences an obstacle in carrying out the desired action, and then experiences negative feeling states when the action is not carried out” (p. 376). Epstein and Hamric (2009) maintain that moral distress is a consequence of compromised integrity and that it is different from psychological distress, which does not necessarily involve violation of core values and duties. Epstein and Delgado (2010) simplify Jameton’s definition, calling moral distress “a phenomenon where one knows the right action to take but is constrained from taking it” (p. 1).

Nathaniel (2002) defines moral distress as “the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet as a result of real or perceived constraints, participates in perceived moral wrongdoing” (p. 3). The limitation of Nathaniel’s positivist definition is that it does not accommodate the complicated layers present when there is ethical indecision or values conflict. Other definitions do not say participation in perceived moral wrongdoing

must be present to experience moral distress. It is of note that sometimes moral distress is a result of inaction or remaining silent about observed moral discrepancies.

For the present study, the American Association of Critical-Care Nurses' (AACN) (2004) definition is used that describes moral distress as "painful feelings and/or psychological disequilibrium that occurs in situations in which the ethically right course of action is known but cannot be acted upon due to internal or external constraints. As a result, persons with moral distress act in a manner contrary to their personal and professional values which undermines their integrity and authenticity" (AACN, 2004, p. 1).

Research with Nurses and Moral Distress. Research about nurses' experiences with moral distress has steadily progressed since Jameton (1984) first gave the concept its name. Most researchers used qualitative methodology to explore moral distress (Ferrell, 2006; Gutierrez, 2005; Wilkinson, 1988). Corley's theory is an excellent example of progress in knowledge development related to moral distress. Research instruments were developed that can be used to assess characteristics of moral distress, as well as intensity and frequency of occurrence. Researchers have also examined sources of moral distress and sought to identify relationships with different demographic variables.

Assessment of Moral Distress. The first attempt to measure moral distress used a one-item visual analogue scale, which reported levels of moral distress (Corley & Selig, 1994). Corley (1995) began development of a quantitative instrument to measure the moral distress of critical care nurses. She sought to identify the causes and severity of moral distress. Corley's original instrument, the *Moral Distress Scale (MDS)*, is an eight point Likert scale (0 to 7) questionnaire containing 32 contextual situations, such as

prolonging life, performing unnecessary tests and treatments, lying to patients, and incompetent or inadequate care by physicians. Corley, Minick, Elswick, and Jacobs (2005). conducted further research with the *MDS* in studying the relationship between moral distress and ethical work environments. Items about pain management, managed care, and incompetent health care personnel were added to the instrument based on information from previous surveys for the study. The final survey consisted of 38 items. Corley's *MDS* has been widely used in research on moral distress (Corley et al., 2005; Elpern, Covert, & Kleinpell, 2005; Meltzer & Huckabay, 2004; Pauly, Varcoe, Storch, & Newton, 2009; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Zuzelo, 2007).

Hamric revised Corley's *MDS* for use in a pilot project to explore the perspectives of RNs and physicians in caring for dying patients in intensive care units (Hamric & Blackhall, 2007). Hamric has further updated The *Moral Distress Scale-Revised (MDS-R)* to include 21 clinical situations which may or may not be disturbing to nurses (A. B. Hamric, March 22, 2011, personal communication). The revisions to Corley's instrument included eliminating redundant items, items reflecting outdated expectations of health professionals, and items infrequently experienced according to earlier studies. The situations deal with aggressive end-of-life care, incompetent care, institutional constraints, deception of patients, inadequate pain management, and ignoring patient autonomy. The instrument is constructed in a five point Likert format (0 to 4). Participants rate both the frequency and the intensity of the moral distress each situation causes. After scoring the situations, participants are given the opportunity to describe any clinical situations in which they had felt moral distress. At the end of the survey, participants are asked if they have ever left or considered leaving a position due to moral

distress or whether they are currently considering leaving their position due to moral distress (A. B. Hamric, March 22, 2011, personal communication).

Sources of Moral Distress. Research in this section reveals several contextual, patient care, and nurse factors identified as root causes for the experience of moral distress in nursing. Results vary about the number of nurses who experience moral distress and which clinical situations are most distressing to nurses and which occur most frequently. The results of moral distress studies have similarities and differences, most likely influenced by setting and population.

Corley (2002) addresses both the internal (nurse's psychological responses) and external (work environment) contexts in which moral distress develops in her theory of moral distress. Corley's theory focuses on institutional (external) constraints as an impediment to nurses implementing moral decisions. External constraints are mainly those that occur within the work environment such as inadequate staffing, lack of time, hierarchies within the health care system, lack of administrative support, policies and priorities conflicting with care needs, and compromised care due to pressure to reduce costs. Corley (2002) cites several common sources of moral distress such as continued life support that is not in the best interest of the patient, inadequate communication about end-of-life care between providers and patients and families, inappropriate use of health care resources, inadequate staffing or inadequately trained staff to provide the required care, inadequate pain relief provided to patients, and false hope given to patients and families.

Rice, Rady, Hamrick, Verheijde, and Pendergast (2008) used Corley's *MDS* to examine the prevalence of moral distress and contributing factors of 260 medical and

surgical nurses at an acute tertiary center in the southwestern U.S. Rice et al. discovered that moral distress intensity was consistently highest in the following categories: physician practice; nursing practice; institutional factors; futile care; deception; and euthanasia. Frequencies of occurrence were highest with futile care and with situations of nursing practice (e.g., staff ratios, incompetence).

Wilkinson (1988) explored the phenomenon of moral distress experienced by nurses working in hospitals. Wilkinson conducted qualitative interviews with 13 hospital staff nurses and 11 non-staff hospital nurses. She sought to generate a theory about the relationship between moral aspects of nursing practice and quality of patient care. Nurses in Wilkinson's study perceived external constraints for moral actions to be physicians, lawsuits, nursing administrators, and institutional policies. They described receiving little support from physicians or administration with moral issues. The internal constraints identified in Wilkinson's study included lack of courage, self doubt, lack of autonomy in decision making, and fear of losing jobs. Nurses' sense of powerlessness in making patient care decisions has also been reported by participants in subsequent studies of moral distress (Millette, 1994; Gutierrez, 2005).

In Wilkinson's (1988) study, the most described experiences with moral distress involved prolongation of life with aggressive care for dying patients, performing unnecessary tests and treatments (especially in terminally ill patients), lying to patients, and incompetent or inadequate treatment by a physician. The most frequently described moral issue involved harm to patients in the form of pain and suffering, and dehumanizing treatment of patients.

Wilkinson (1988) discovered from her interviews that moral distress did not solely relate to the particular type of moral situation that occurred. The individual nurse's belief system was also influential as to whether or not the nurse experienced moral distress from the same situation. The nurses described moral distress as a frequent occurrence. The nurses did acknowledge that it was dependent on the unit they worked in, as well as the personal values they held.

Corley (1995) sought to determine the level of moral distress experienced by critical care nurses and to delineate situations frequently causing moral distress. The sample consisted of members of a chapter of the AACN, critical care nurses working in a large medical center, and critical care nurses working in a private hospital. Results of the study showed aggressive care to be the source of greatest distress. Dishonesty with patients and unnecessary testing were the second and third most frequent causes of distress, respectively. Nurses working in private hospitals reported significantly greater moral distress with aggressive care than those nurses working in academic settings. Nurses currently working in intensive care units (ICU) (65% of the sample) experienced lower levels of moral distress related to aggressive care of the hopelessly ill than nurses in non-ICU settings.

Inadequate nursing staff is an institutional constraint which is an impediment to nurses being able to provide the care patients need (Corley et al., 2005). Corley, Elswick, Gorman, and Clor (2001) performed a quantitative study of nurses, most employed in critical care, which was designed to evaluate the Corley *MDS*. Unsafe levels of nurse staffing ($M = 5.47$), as well as carrying out orders for unnecessary tests and treatments on terminally ill patients ($M = 5.44$), received the highest scores for moral distress. In a later

study, Corley et al. (2005) also found that working with staffing levels perceived as unsafe caused the highest moral distress intensity and occurred most frequently.

Futile care is defined as “life-saving care which is highly unlikely to result in meaningful survival” (Ferrell, 2006, p. 922). Futile care is an issue which affects nurses, especially those caring for dying patients. Futile care has social, legal, and ethical implications. It was a major source of moral distress for nurses in Ferrell’s (2006) qualitative study of nurses’ experiences resulting from caring for patients receiving treatments they considered futile. Ferrell queried 108 nurses attending end-of-life care conferences. The nurses were employed in high technology settings with a focus on prolonging life. Ferrell examined narratives using thematic analysis. The predominant theme was “aggressive care denied patients palliative care” (p. 928). Nurses expressed distress that futile aggressive care denied patients the ability to die at home surrounded by loved ones with adequate pain management and with having their spiritual and physical needs met. The nurses believed the treatment wishes of the patient’s family or the physician were placed above the patient’s own desires.

Futile care was also found to be a source of moral distress for nurses by Elpern et al. (2005). They conducted a descriptive study with critical care nurses to identify levels of moral distress, factors associated with moral distress, and implications of moral distress. Elpern et al. (2005) reported moderate levels of moral distress among the critical care nurses ($M = 3.66$, $Range = 1.76$ to 5.79 , $SD = 1.73$) on the Corley *MDS*. Both the highest intensity levels (5.37) and highest frequency levels (4.63) of moral distress were associated with the provision of aggressive care with no perceived patient benefit (futile care).

Gutierrez (2005) studied 12 critical care nurses in a large Midwestern hospital using open-ended interviews to elicit nurses' clinical experiences with moral distress. Gutierrez found three common moral conflicts that contribute to moral distress. First, nurses identified overly aggressive medical treatment that increased patient suffering as a major source of moral conflict. Second, inappropriate use of health care resources was a major factor contributing to moral distress. Third, withholding or giving inaccurate information to patients and families by physicians resulted in moral distress for the nurses. Gutierrez reported that nurses described their biggest constraint as incongruent patient care goals between the physician, family, and nurse. This incongruence kept the nurses from taking action consistent with their moral judgment and led to moral distress.

Pauly et al. (2009) conducted a quantitative cross-sectional survey with Corley's *MDS* and Olson's *Hospital Ethical Climate Survey* to obtain measures of moral distress and associated ethical climate among practicing nurses in British Columbia, Canada. Pauly et al. reported a moderate level of moral distress among the nurses along with an association with the hospital's ethical climate ($r = -0.420, p < .01$). The highest scoring moral distress situation in terms of intensity on a 6-point scale was working with unsafe levels of registered nurse staffing (4.63). Other situations causing the highest levels of moral distress were: (1) being required to care for patients the nurse feels incompetent to care for (4.56); (2) working with RNs less competent than required (4.52); (3) working with physicians less competent than required (4.47); and (4) assisting a physician who is (in the nurse's opinion) providing incompetent care (4.44).

Winland-Brown et al. (2010) conducted a descriptive correlational study to compare the perspectives on moral distress of 174 nurses, 10 nurse practitioners, and 14

physicians. The study was conducted in two hospitals and a hospice in South Florida. They examined the intensity of distress, but not frequency of occurrence. Situations causing significant distress for both RNs and physician groups were ranked as following: (1) deceiving patients; (2) assisting incompetent physicians; (3) not discussing death with patients who asked about it; (4) working with physicians/nurses not as competent as needed by the patient; and (5) ignoring situations of suspected patient abuse by caregivers. The narratives revealed common themes of distress: questionable activities of colleagues; patient care being sacrificed due to scarce resources; lack of communication; prolonging life in futile situations; and ignoring advance directives.

Zuzelo (2007), using a modified Corley's *MDS*, conducted a quantitative descriptive study with a convenience sample of 100 RNs providing direct care in inpatient units in a large health care network to explore their morally distressing events. Zuzelo contrasted the experiences with the types of formal ethics education programs nurses completed. Zuzelo also sought to identify sources of support that the nurses sought when they found themselves dealing with morally distressing situations. Zuzelo's research revealed that the most morally distressing issue for nurses was working with nurse staffing levels perceived as "unsafe," yielding a moral distress intensity score based on a 6-point scale of 4.14 ($SD = 1.93$). Another issue causing a high level of distress was working with a physician who was not as competent as patient care required ($M = 3.95$). Competency of staff was also a concern. Nurses felt moral distress when they were compelled to assist a physician who, in the nurses' opinion was incompetent ($M = 3.64$, $SD = 2.19$). Participants were distressed with their perceived incompetency of nurses ($M = 3.74$, $SD = 1.9$). Three other situations identified as causes for higher levels of moral

distress were ineffective pain management ($M = 3.7, SD = 1.89$), following family wishes for life support in patients with poor prognoses ($M = 3.68, SD = 1.97$), and carrying out orders for unnecessary tests and treatments ($M = 3.65, SD = 1.74$).

Analysis of the qualitative data in Zuzelo's (2007) study identified themes of morally distressing situations including: (1) resenting physician reluctance to address death and dying; (2) incurring negative consequences from confronting physicians; (3) frustration with the subordinate role; (4) ignoring patients' wishes in treatment plans; (5) frustration with families overriding patient wishes; and (6) treating patients as tools for training of students and physicians.

Corley et al. (2005) conducted a descriptive correlational study with 106 registered nurses working on medical and surgical units in two large mid-Atlantic city medical centers to examine the relationship between moral distress intensity, moral distress frequency, and the ethical work environment. Scores on the *MDS* revealed that working with staffing levels perceived as unsafe had the highest moral distress intensity and frequency scores. Corley et al. found that the more ethical the work environment was observed to be per McDaniel's *Ethical Environment Questionnaire*, the less moral distress intensity the nurses reported.

Meltzer and Huckabay (2004) examined moral distress experiences due to futile care and its relationship to burnout with a sample of critical care nurses using Corley's *MDS* and the *Maslach Burnout Inventory*. The descriptive survey found that the frequency of moral distress situations considered by nurses as futile care or as providing no benefit to their patients was positively correlated ($r = .317, p = .05$) with the experience of emotional exhaustion. Regression analysis revealed scores on the *MDS*

frequency subscale were significantly associated with scores on the *Maslach Burnout Inventory (MBI)* emotional exhaustion subscale ($p = .01$). The authors noted that emotional exhaustion occurs “when a person’s appraisal of occupational stressors exceeds his or her coping capabilities or they conflict with the person’s values and belief system so that he or she cannot cognitively reconcile with the stressors or cope” (p. 206).

Demographic Factors and Moral Distress. Researchers, when studying moral distress, frequently searched for any relationships between moral distress and various demographic variables of participants. Most studies revealed no significant associations with demographics and moral distress. Corley’s (1995) study found that age, education, and experience had no significant effects on moral distress. In subsequent moral distress research with critical care nurses, none of the demographic variables of age, education, gender, work experience, work setting, or years in current position made a significant difference when measuring the level of moral distress (Corley et al., 2001).

Similar demographic results were obtained by Cavaliere, Daly, Dowling, & Montgomery (2010) in their study of moral distress in neonatal intensive care unit nurses. They found no correlation between the level of moral distress and age, years in current neonatal intensive care unit position, years of nursing experience, religion, marital status, or previous knowledge of moral distress. Winland-Brown et al. (2010) reported no significant findings relating moral distress to religious affiliation, ethnicity, and amount of ethics education in their moral distress research.

Relationships were found between moral distress and certain demographic characteristics in other studies of moral distress. Meltzer & Huckabay (2004) found a significant relationship between educational level and moral distress. Their results

indicated that nurses with a bachelor's degree in nursing or higher had significantly higher scores ($p = .009$) on the "painful feelings with situations of medical futility" subscale of the *MDS* ($M = 154.19, SD = 30.10$) than did nurses with an associate degree in nursing ($M = 126.58, SD = 34.87$). This result indicated that nurses with a bachelor's degree or higher experienced more painful feelings when confronted with situations of medical futility than did nurses with an associate degree. This result is similar to that which Erlen and Sereika (1997) found in their investigation of the relationship between ethical decision making and stress in ICU nurses. Nurses with a bachelor's degree or higher had higher stress-related scores than did nurses with an associate degree in their study.

Rice, Rady, Hamrick, Verheijde & Pendergast (2008) reported nurses caring for transplant and oncology patients most frequently encountered moral distress situations than others in the sample. Rice et al.'s study also showed that nurses who were over 34 years of age experienced the most intense moral distress in response to futile care ($p = .04$). Current employment of over three years, and nursing experience of over six years predicted a higher intensity of moral distress with the other categories. Finally, nursing experience of more than six years, and caring for oncology and transplant patients were factors significantly associated with increased encounter frequencies of moral distress situations.

Corley et al. (2005) revealed that age negatively correlated with moral distress intensity ($p = .05$); the older the nurse, the less moral distress intensity was observed using the *MDS*. Race (African American) correlated with moral distress intensity ($p = .01$). African-American nurses had higher levels of moral distress intensity on the *MDS*

compared with those who identified as Caucasian, Hispanic, or Asian. A moral distress intensity/frequency score created by multiplying the intensity score by the frequency score did not yield any significant findings related to demographics.

Demographic variables were analyzed in relation to moral distress scores by Elpern et al. (2005). Years of nursing experience were associated with higher moral distress scores and were the only significant association found ($p = .02$). This result discounts the idea that nurses become “desensitized” to moral distress over time.

Unpublished results from pilot testing of the *MDS-R* with 163 intensive care unit RNs, demonstrated RNs with more experience to have higher moral distress ($p = .037$) (A. B. Hamric, March 22, 2011, personal communication).

Consequences of Moral Distress. Moral distress has consequences for individual nurses, for patients, and for institutions. Moral distress is a negative phenomenon for nurses because of the violation of one’s core values and obligation as patient advocate. It occurs as a result of nurses’ attempts to preserve moral integrity. Jameton (1984) emphasizes that moral distress elicits “painful feelings and/or the psychological disequilibrium” (p. 6). Jameton proposes that reactive distress can result in psychological consequences such as feelings of worthlessness and lack of confidence. Reactive consequences can also result in physiological symptoms such as headaches, palpitations, and changes in body functions. If these effects persist for extended periods, they can have a serious impact on the nurse’s practice as well as quality of life.

Many nurses express moral distress through psychosocial responses such as anger; loneliness; depression; guilt; anxiety; feelings of powerlessness; and emotional withdrawal (Corley, 2002; Elpern, 2005; Fry et al., 2002; Wilkinson, 1988). These

responses may lead to related physiological symptoms. In Wilkinson's (1988) study, participants reported feelings of anger, frustration, and guilt resulting from dealing with workplace constraints. Wilkinson (1988) reported that nearly all of the nurses said moral distress affected their professional "wholeness."

Elpern et al. (2005) found that nurses reported developing somatic complaints such as sleeplessness and physical illness. They also experienced feelings of powerlessness, hopelessness, and lack of support. These participants' descriptions support the premise in Corley's theory that moral distress has adverse psychological and physiological effects on nurses.

Open-ended comments from respondents reported by Elpern et al. (2005) who claimed job dissatisfaction and who said they were presently considering leaving their current positions resulted in some interesting remarks. For example, "I have thought of leaving the medical intensive care unit because of the sad and depressive state our patients are in" (p. 525). Another comment vividly described the nurses' feelings about futile care: "I often equate my job to keeping dead people alive. On these days, I dread coming to work" (p. 525).

In qualitative research by Ferrell (2006) examining experiences of moral distress in response to futile care, participants were asked about the personal impact of moral distress. Many related that they felt demoralized and that they had failed the patient as an advocate. They also spoke of feelings of helplessness, anger, and distress. Many nurses detailed experiences that had occurred early in their careers, revealing the long-lasting impact of moral distress on nurses. A perceptive finding was that nine of the nurses reported that their experiences caused them to leave their acute care units and become

hospice or palliative care nurses. This suggests nurses might experience more congruence with their value of patient caring and advocacy in practice situations that support a peaceful death for their patients.

Gutierrez (2005), in her study of nurses' clinical experiences with moral distress, found that many of the participants relied on other staff nurses to help cope with the negative feelings caused by morally distressing experiences. Some relied on their family and friends for support, while others stated that they had no support mechanism for their negative feelings. According to Corley's (2002) theoretical framework, when there is no support or intervention opportunity for nurses, they are likely to suffer from lasting moral residue and eventually leave the profession.

Corley's theoretical model identifies moral residue as a consequence of moral distress. Webster and Bayliss (2000) say that moral residue is "that which each of us carries with us from those times in our lives when in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 208). Elpern et al. (2005) suggested that moral distress may yield a cumulative effect and as distressing experiences increase, it results in "moral residue." Epstein and Hamric (2009) describe moral residue as the "lingering feeling after a morally problematic situation has passed" (p. 332).

Webster and Bayliss (2000) purport that yielding one's values in these situations leads to a loss of moral identity which leads to moral residue. Moral residue can be powerful and long lasting. This type of residual effect from moral distress is evident from the qualitative studies reviewed in this section (Epstein, 2007; Ferrell, 2006; Fry et al., 2002; Guitierrez, 2005; Torjuul & Sorlie, 2006; Wilkinson, 1988; Zuzelo, 2007).

Participants would tap into intensely wounded feelings when asked to relate their experiences with moral distress, even though the incidences occurred years earlier. Nurses who related their stories about moral distress could easily recall vivid details and the feeling intensity. Epstein (2007) reported that one nurse stated:

“Years ago with an ECMO (extracorporeal membrane oxygenation) patient that was clearly dying, I said to the physician ‘Do you truly believe by doing this it is going to change the outcome?’ He said, ‘Well, no it won’t,’ and I said, ‘Why are we doing this?’ And the physician said, ‘Because we can.’ That kind of thing bothers me” (p. 214).

Ferrell (2006) reported one participant stating:

“My first experience with death, as a new nurse, was a frail man who came into the intensive care unit (ICU) after he coded at home. The patient coded again shortly after his arrival in the ICU. As I mentioned before, this patient was very frail, emaciated, and his body was bright yellow-orange. The doctor in the unit was a young intern. He led the code. It was evident to all the nurses on the unit the code should have been called. But the intern insisted on continuing. By the time he called the code, there were many ribs broken. The memory of that patient has been etched in my mind since 1972. That was when this incident occurred” (p. 927).

Moral distress is also a threat to patient care quality. Researchers suggest that among nurses, moral distress and compromised moral integrity have been associated with nurses losing their capacity for caring, avoiding patient contact, and failing to give good

physical care to patients (Corley, 1995; Kelly, 1998; Redman & Fry, 2000; Wilkinson, 1988). Moral distress contributes to nursing shortages which have been linked to negative patient outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Bae, Mark, & Fried, 2010; Ke-Ping Yang, 2003).

There is a tendency by nurses who experience moral distress to withdraw emotionally and physically from patients. Corley (2002) theorizes that moral distress results in nurses avoiding patients and not advocating for patients, leading to increased patient discomfort and suffering. Hamric (2007) also asserts from her research that the compromising effect of moral distress on health professionals' moral integrity is a negative consequence that can result in compromised care for patients.

Nurses may be reluctant to view their distress as affecting patient care. Wilkinson (1988) revealed that nurses were divided about whether the moral distress affected their ability to give patient care, yet reported some avoidance of patients. Wilkinson theorized that nurses underestimated the effect of moral distress on patient care for four reasons. First, it was threatening to their self-image as "good" nurses. Second, they defined quality of care in relation to physical care only. Third, they measured quality of care as a reflection of their own output rather than considering patient outcomes. Fourth, they failed to consider the care they could have provided if their wholeness had not been affected by moral distress (Wilkinson, 1988, p. 22).

Interviews with nurses reveal their attempts to ameliorate the effects of moral distress by separating themselves from the source of distress. Elpern et al. (2005) reported that nurses developed aversive attitudes toward patients. One nurse's statement described this phenomenon as follows, "I find myself listening to report to get an

assignment that excludes certain patients” (p. 327). Gutierrez (2005) found that several participants, though denying any effects on patient care, asked for reassignment from caring for the patient that placed them in the in the moral distress situation. Some nurses also reported decreased interaction with patients’ families.

Raines (2000) reported that nurses used distancing strategies with patients as a consequence of the ethical decision-making process. Raines used a descriptive survey with a nationwide sample of 229 oncology nurses to explore ethical decision-making in nurses. Results indicated nurses had experienced an average of 32 different types of ethical dilemmas within the past year on a daily basis. Raines found that the participants managed ethical stress by distancing and escape-avoidance strategies towards patients. As a result, nurses reported detaching emotionally from their patients and their work.

Moral distress also has a deleterious effect on health care organizational functions. Corley (2002) theorizes that moral distress creates retention and recruiting difficulties for health care institutions. Studies previously described where nurses left positions or the profession due to moral distress support that premise (Cavaliere, 2010; Corley, 1995; Corley et al., 2001; Hamric & Blackhall, 2007). Any issue which causes nurses to distance themselves from patients or remove themselves from direct patient care, will compound the effects of the present nursing shortage on patient care. Adequate numbers of skilled and competent nurses are needed to ensure quality patient care. If moral distress is pervasive, the institution’s accreditation and survival may be threatened.

In summary, studies examining moral distress demonstrate that nurses do indeed experience moral distress in their practices. Most studies were conducted with specialty groups of nurses such as those in high acuity areas. Quantitative studies revealed that

situations such as futile care, unsafe staffing, patient deception, and working with perceived incompetent colleagues were highly distressful for nurses. Qualitative studies were enlightening about the depth and duration of the pain associated with moral distress. The effects from moral distress inevitably filter down and affect patient outcomes as well as organizational processes.

Nurse Satisfaction and Retention

With the current prolonged nursing shortage and impending increased need for health care services, it is more important than ever to explore the topic of nurse satisfaction in order to improve retention rates. Moral distress can be a compounding problem that further exacerbates staff shortages, since burnout and dissatisfaction have been noted as consequences of moral distress (Meltzer & Huckabay, 2004).

Values congruence with an organization has been identified as important for nurses' satisfaction and their decisions to remain in the workplace (Sorlie, Kihlgren, & Kihlgren, 2005). Values dissonance can create ethical conflicts for nurses. Wilkinson (1988) reported that when nurses' values were congruent with those of physicians and hospitals, they experienced less moral distress. Thus, a health care organization's mission, vision, and philosophy can be a source of moral comfort or distress and a factor in nurse satisfaction.

The practice of nursing can offer a source of deep satisfaction. Perry (2005) conducted a phenomenological study of international registered nurses to identify factors contributing to professional fulfillment. The deep human connection to patients and their families was the theme that arose as central to the nurses' professional fulfillment. Those nurses who provided what they perceived as quality care and made strong connections

with their patients were ones most satisfied with their nursing careers. The nurses' narratives revealed that making connections to patients was accomplished through affirming the value of persons; defending their dignity, enabling hope, and helping patients find meaning in the illness experience. Perry developed a model of career satisfaction in which nurses live out their core nursing values through their practices. When nurses connect and make a difference for their patients, the nurses receive positive reinforcement from that experience and are motivated to continue in the profession.

Fagermoen (1997) reported that nurses' narratives of professional identity were concentrated on values that were patient-focused. Providing personalized care made the nurses' practice meaningful. The nurses found satisfaction in interacting with patients, enabling them to develop a sense of trust in the nurses. Nurses also found satisfaction in providing skilled, competent physical care. They reported that working as nurses "maintained and enhanced their self-concept, both as nurses and persons" (Fagermoen, 1997, p. 440). The nurses stated that the meaning for their work was found in providing care and through the relationships they developed with patients.

Pask (2003) interviewed five nurses to examine the nature of moral agency in nursing and examined how nurses find value in their work. Interview responses revealed that the nurses experienced value "intrinsic to the moment" in the specific patient-care situation where they knew their presence on that particular day made a difference. Nurses also perceive value in their work when they are able to exercise their moral sensitivity about how they ought to act professionally, and "the self of the nurse achieves that which she or he sets out to achieve" (Pask, 2003, p. 170). Nurses found fulfillment in the realization that their care was person-focused and made a difference. One nurse

participant described what sustained her in her work was “going in and doing something that made a difference to that person...doing something that was important to them, and which made a difference to them. Made them feel better in some way”

(p. 166). Personal encounters, where the nurse experiences the “other,” leaving his or her egoistic self behind, were the moments the nurse participants described as “what’s really keeping me going” (p. 166) when dealing with the everyday strains of nursing practice.

There are studies that examine nurse dissatisfaction. Enns and Gregory (2007) reported that nurses had sources of dissatisfaction in their jobs caring for patients. They described their work in terms of performing fragmented tasks rather than caring for the person as a whole. Participants perceived a lack of support from nursing administration in providing assistance, answering questions, and mentoring new graduates. While the nurses acknowledged the benefits of technological advances, they believed the advances consumed more of their time, resulting in less time for their patients. Participants reported that higher acuity levels of patients did not match staffing levels. They expressed feeling “stranded at the bedside” (p. 342), with other health care personnel unwilling or unavailable to provide assistance. There were many times when they felt “frustrated, exhausted, and alone” (p. 342). Finally, participants expressed a lack of caring among nurses, which they deemed unprofessional. They expressed that nurses caring for each other in today’s stressful workplace is necessary in order to create a caring environment for patients and their families.

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) found that burnout, job dissatisfaction and retention are related. In their cross-sectional analyses 10,184 staff nurses from 168 hospitals in Pennsylvania were surveyed. Aiken et al. found that 43% of

nurses reported high levels of burnout and job dissatisfaction and intended to leave their current job within the next 12 months. Among those who reported low levels of burnout and job satisfaction, only 11% reported an intention to leave. Aiken et al. also found that both higher emotional exhaustion and greater job dissatisfaction in nurses were significantly associated with nurse-patient ratios. The researchers found that with each increase in one patient per nurse, the odds of burnout increased by 23% and job dissatisfaction increased by 15%.

Aiken et al. (2001) used the *MBI* in an international study to measure emotional exhaustion (a component of burnout) and the extent to which nurses felt overwhelmed by their work. Surveys were conducted in five western countries and included 711 hospitals and 43,000 nurses. Results showed that the 13,471 U.S. nurses in the study had 30 to 40% higher scores of emotional exhaustion relative to the norms for medical workers that were established by the developers of the *MBI*. Aiken et al. (2001) discovered more than two in ten in the United States and more than three in ten nurses in England and Scotland planned on leaving their jobs within the next year. Of those nurses planning to leave their jobs, there was a higher percentage of nurses under age thirty in all the countries. Compounding this problem of retention is the aging nursing population. These data suggest the future of nurse retention for hospitals years is in jeopardy unless these negative trends are arrested.

Researchers have studied characteristics of institutions to develop strategies that promote nurse retention. Shader et al. (2001) used a cross-sectional design in research on nurses' perceptions of job stress, work satisfaction, group cohesion, and anticipated turnover. Their research revealed that more job stress was associated with lower group

cohesion, lower work satisfaction, and not surprisingly, higher anticipated turnover. Conversely, higher work satisfaction was associated with higher group cohesion and lower anticipated turnover. Job stress, work satisfaction, group cohesion, and weekend overtime were predictors of anticipated turnover. Job stress was a significant predictor of anticipated turnover in nurses aged 20 to 30. For the 31-40 year-old nurses, work satisfaction was predictive of anticipated turnover. In the 41-50 year-old nurses, work satisfaction and group cohesiveness were predictive factors for anticipated turnover. There were no significant predictive factors in the nurses 51 years and older.

Hayhurst, Saylor, and Stuenkel (2005) used a descriptive, correlational design to compare retention factors associated with nurse turnover. The researchers found that the perception of peer cohesion was higher among nurses who stayed in their position over six months than those who left. Perceptions of supervisor support were also higher among nurses who stayed in their positions for at least six months. Hayhurst et al. (2005) found that autonomy was higher among nurses who stayed in their positions, but did not reach statistical significance ($p = .58$). Perceptions of work pressure were lower among nurses who stayed in their positions, but also not statistically significant ($p = .23$). Hayhurst et al. reported the trend for younger nurses (ages 20 to 29 years) and those with less than two years of seniority, leaving more often than those in other demographic categories. Peer cohesion and supervisor support may suggest that there are shared professional values, making the workplace a morally comfortable environment.

Parry (2008) was concerned that studies on nurse retention often did not discriminate between nurses who left one position for another and those who left the profession altogether. Parry decided to add the construct of affective professional

commitment as a significant factor related to nurse retention. Affective commitment occurs when a person has positive feelings about her or his profession and identifies with it. Parry hypothesized that persons affectively committed to their profession desire to act in ways that are consistent with the profession's values and are more likely to remain active in the profession. Parry thought that when there is a high level of affective professional commitment that is reinforced by the particular organizational work environment, job satisfaction is more likely and nurses are more likely to remain in the profession.

Parry (2008) used a repeated measure design with a sample of 131 Australian nurses with bachelor's degrees. Measurement was accomplished using the affective component of the *Blau occupational commitment measure*, *Price's job satisfaction measure*, the revised *Organizational Commitment Questionnaire*, and Bozeman and Perrewé's *Organizational Turnover Intention Scale*. Data were collected at two points in time, prior to or soon after workplace entry, and after six months exposure to the workplace. Results confirmed that job satisfaction and organizational commitment were associated with nurses' intentions to remain in their positions within an organization, and that commitment to the profession by itself was not enough to retain nurses. Parry emphasizes the importance of attending to restraints imposed on nurses' abilities to provide quality care, seeing this as a major consideration for retaining nurses in their chosen profession.

The perception of ethical climate has been an important factor in the development of moral distress and nurse retention. Ulrich et al. (2007) conducted a study to explore this relationship with 793 social workers and 422 nurses from California, Maryland,

Massachusetts, and Ohio. Ulrich et al. developed a composite questionnaire, using adapted sections from *Olsen's Hospital Ethical Climate Scale*, *Raines' Ethics Stress Questionnaire* (that looks at ethical issues, socio-demographic and practice characteristics, and resources available to deal with ethical issues), and from *Williams' Physician Job Satisfaction Scale* (that looks at job satisfaction and intent to leave).

A higher ethics stress score for participants was associated with a lower ethical climate score. Ulrich et al. (2007) found that ethics-related stress had a stronger relationship to job satisfaction than the influence of staffing levels on nurses' decisions to leave. Thirty-five percent of respondents cited their level of ethical conflict as strongly influential in the level of job satisfaction. Participants reported that both respect in the workplace and belief in the institutional mission were more important than salary and staffing levels for retention. Only 58% of participants in the study reported there was trust between themselves and physicians (Ulrich et al., 2007). Thirty-two percent reported they felt powerless in ethical situations and 39% reported they had no resources to help in those situations. Thirty-seven percent of the social workers and nurses cited issues that made their jobs more difficult. Being respected and valued as a team member was reported most often (75%) by participants as the factor most influencing their decision to remain in a position. Ulrich et al. (2007) found that 25% of the social workers and nurses reported a desire to leave their current positions and 41% could not say they would choose their profession again. The majority of those in the study stating a desire to leave their positions were younger workers and workers who worked full time.

Hamric and Blackhall (2007) found an association of moral distress with perception of ethical climate in a pilot study with 29 physicians (MDs) who admitted

patients to intensive care units and 196 RNs caring for those patients. The purpose of the research was to explore the experiences of MDs and RNs caring for dying patients by examining the relationships among moral distress, ethical climate, RN/MD collaboration, and satisfaction with quality of care. Hamric and Blackhall used a modified Corley's *MDS* to measure moral distress and modified McDaniel's *Ethics Environment Questionnaire* to measure perception of ethical climate. They reported that RNs with high moral distress had significantly lower ethical climate/environment scores than did RNs with lower moral distress ($p = .001$) (Hamric & Blackhall, 2007).

Hart (2005) confirms the importance of ethical climate in retention of nurses. Hart examined registered nurses' perceptions of the hospital ethical climate and their intentions to either leave their position or leave the nursing profession altogether. Multiple linear regression analyses were calculated to explain positional and professional turnover intentions based on demographic factors and employment characteristics, including hospital ethical climate. Results showed that the hospital ethical climate was the most important factor for explaining nursing positional turnover intentions ($p < .001$). Hospital ethical climate, control over one's practice, and patient load had the most effect on professional turnover intentions ($p < .001$). The use of educational reimbursement as a retention strategy, and sufficient staffing levels were all significant for preventing positional turnover. Hart found that nurses who had higher perceptions of an ethical climate in the workplace and had more autonomy in their practice were more likely to report a higher intent to stay in their current positions (perceived powerlessness is considered an antecedent to moral distress). The use of retention bonuses had no effect on whether or not nurses intended to stay in their current positions or in the profession. Hart

also found that additional ethics education and having ethical conflicts in past positions helped contribute to nurses' intention to stay in their current positions.

Effect of Nurse Turnover on Patients. Nurse shortages increase workloads for those nurses caring for patients. Patients frequently receive less care than is required, and may suffer serious consequences from less than competent care. Nurse turnover only exacerbates the nursing shortage in health care. Aiken et al. (2001) reported that only 30 to 40 % of nurses thought there were enough registered nurses to provide high-quality care and sufficient staff to get the work done. In the same study, nearly half of the nurses in the U.S. and Canada believed that the quality of patient care in their institutions had deteriorated in the past year.

Bae, Mark, and Fried (2010) also examined the effects of nurse turnover on patient care. Bae et al. (2010) questioned the consequences of nursing unit turnover on patient outcomes in hospitals and developed a model to illustrate those consequences. They postulate that high turnover rates cause instability in the nursing workgroup which in turn disrupts the patient care functions transpiring on a unit. The aim of their quantitative study was to examine how nursing unit turnover affects key workgroup processes and in turn, how these workgroup processes influence patient outcomes. Patient-related outcomes measured in the study were patient falls, average length of stay, and medication errors.

Nursing units with moderate levels of turnover were likely to have lower levels of workgroup learning compared to those with no turnover ($p < .01$) (Bae et al., 2010). Nursing units with low levels of turnover were likely to have fewer patient falls than other nursing units ($p < .05$). Additionally, workgroup cohesion and relational

coordination had a positive impact on patient satisfaction ($p < .01$), and increased workgroup learning led to fewer medication errors ($p < .05$). This study shows the mediating effects of workgroup processes on patient outcomes. It highlights the importance of nurse retention at the unit level to enhance or maintain workgroup effectiveness, which in turn leads to fewer adverse patient outcomes.

Aiken et al. (2002) conducted a study on the relationship between hospital nurse staffing and patient mortality. They examined discharge data of 232,342 patients to identify those patients who died within 30 days of admission (mortality) and patients who succumbed to “failure to rescue” (meaning they died within 30 days of admission from complications during hospitalization). Aiken et al. found significant effects with nurse staffing on patient mortality and failure to rescue. Mortality was found to increase by 7% for each additional patient assigned to a nurse’s workload. Increasing a nurse’s workload from four to six patients would increase patient mortality by 14%. Increasing the workload from four to eight patients resulted in a 31% increase in patient mortality. The results from this study emphasize the deleterious effects of nurse staffing shortages on patient outcomes.

Another study supporting the negative impact of nurse shortages on patient outcomes was conducted by Ke-Ping Yang (2003). She studied the relationship between nurse staffing and patient outcomes for 21 inpatient units in a tertiary care center in Taiwan over a period of one fiscal year. Results determined that the ratio of RNs to patient census was inversely related to the unit rates of patient falls, urinary tract infections, and patient or family complaints. Ke-Ping Yang’s study demonstrated that nursing workload was significantly and positively correlated with respiratory tract

infections, patient or family complaints, and patient acuity. The nursing workload was also a powerful predictor of both nosocomial infections and the five adverse outcome indices (patient falls, pressure ulcers, respiratory tract infections, urinary tract infections, and patient/family complaints).

From studies reviewed in this section, it is clear that nurse turnover negatively impacts patient care. Heavy workloads and a loss of workgroup effectiveness have a direct influence on patient outcomes. The studies provide evidence of the consequences of nurse staffing shortages on patient outcomes, and the importance of addressing issues, such as moral distress, that contribute to the shortages.

Moral Distress and Turnover. Moral distress places a heavy burden on nurses to cope with the negative feelings and consequences which accompany moral distress. As their resources for dealing with moral distress become depleted, nurses may experience burnout and reduced job satisfaction, which may prompt them to leave the setting or the profession. Researchers have found moral distress to be a powerful factor in nurse retention.

Corley (2002) theorizes that burnout is a consequence for nurses who experience moral distress. Burnout may result in nurses leaving positions or the profession itself. Meltzer & Huckabay (2004) link moral distress to burnout in the nursing profession. In a descriptive study of 60 critical care nurses, Meltzer & Huckabay found a significant positive correlation ($p = .05$) between scores on the emotional exhaustion (a component of burnout) subscale of the *MBI* and frequency scores on the *MDS*. Linear regression also revealed frequency scores on the *MDS* accounted for 10% of the variance with scores on the *MBI* emotional exhaustion subscale ($p = .01$).

Research about moral distress as a reason for leaving a nursing position or the nursing profession started with Wilkinson's (1988) qualitative study of moral distress with 24 hospital staff and non-staff nurses. Wilkinson found that nearly half of the nurses in her study had left nursing positions and one nurse reported leaving the profession due to moral distress.

Studies demonstrate that nurse turnover due to moral distress is not improving. Corley reported 12% of the participants left a prior nursing position due to moral distress (Corley, 1995), while 15% of nurses reported leaving a previous position due to moral distress (Corley et al., 2001). Hamric and Blackhall (2007) reported that 23% of RNs surveyed had considered leaving due to discomfort with the way end-of-life care was handled in their institutions. Cavaliere et al. (2010) reported that 4.3% of neonatal intensive care unit (NICU) RNs left a previous position due to moral distress, 30.9% said they had considered leaving but did not do so, and 10.6% reported that they were considering leaving their current position due to moral distress. Corley et al. (2005) found that the number of nurses who had actually left a position in the past because of moral distress was considerably higher than other studies at 25.5%. Winland-Brown et al. (2010) found that 22% of RNs had left a position due to moral distress and 26.2% had considered leaving but did not quit. Among advanced registered nurse practitioners, 55.6% had left a position due to moral distress and 22.2% had considered leaving but did not quit (Winland-Brown et al., 2010).

In a qualitative study of 10 nurses from critical care units in Australia by Sundin-Huard and Fahy (1999), nurses who were unsuccessful in patient advocacy attempts

experienced intense moral distress. This resulted in the nurses relocating within the hospital, becoming the object of blame, and/or experiencing burnout.

In summary, nursing turnover is a result of job dissatisfaction, moral distress, and/or burnout. Nurses are frustrated when they are unable to advocate for patients or provide the quality of care they deem essential to the patient's well-being. They may leave a position, or even the profession itself, seeking a practice environment in which they can practice in accordance with their professional values. Nursing turnover can result from adverse working conditions such as excessive workloads and undesirable hours, high patient acuity, psychological demands, negative health care work environments, lack of autonomy, and staffing shortages. Higher turnover rates are reported in organizations where employees' perceptions of an ethical climate are low. Detrimental effects of turnover include negative patient outcomes. Nurses may leave the practice of bedside nursing in order to escape moral distress, leaving a shortage of caregivers. Turnover disrupts the cohesiveness of the nursing care team, decreasing continuity of care, resulting in a cyclical pattern of dissatisfaction and turnover.

Literature Review Summary

Ethics and values are intrinsic to the nursing profession. Nurses are in the role of primary patient advocate, assuming the responsibility to protect the patient who is vulnerable. When nurses enter practice, they frequently find they cannot manifest their professional values due to constraints they encounter in the workplace.

Nurses may experience moral distress when they cannot take what they have determined is the moral action needed to best meet patients' needs. Situations which may cause moral distress include insufficient staffing, futile care, deception of patients,

ignoring patients' wishes for care, unnecessary treatments and testing, incompetent care, and institutional cost containment activities. Corley (2002) clarifies what happens when nurses experience moral distress as a result of feeling unable to advocate for patients. Nurses may experience psychological and/or physiological symptoms in response to moral distress. Unresolved moral distress may lead to moral residue for nurses, which has been found to negatively affect their lives and practices.

Corley (2002) identifies the effects of moral distress on the patient, the nurse, and the organization in specific terms. Patients suffer from lack of advocacy by nurses which results in compromised patient care. Nurses struggling with moral distress may either deliberately or unconsciously avoid patients. If moral distress is not addressed, it may restrict a nurse's ability to provide optimal patient care and find job satisfaction. Nurses experiencing moral distress are more likely to experience burnout and leave their positions or their career. The organization then struggles with a decrease in quality of care and patient satisfaction and an increase in nurse turnover. Once this happens, the organization suffers in reputation and recruiting nurses becomes a full-blown challenge. Thus, moral distress and nurse retention are directly related (Corley, 2002).

Research on the subject of moral distress remains limited. Most studies on moral distress have focused on nurses in critical care settings (Cavaliere et al., 2010; Corley, 1995; Elpern et al., 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004). Moral distress research with nurses working in non-critical care settings is rare or non-existent. Hence, there is a pressing need to include the experiences of moral distress in settings outside critical care units. Except for one study in Florida, the studies on moral distress were conducted in the northeastern United States. Therefore, the

present work was conducted in an effort to extend research on moral distress to include nurses in Georgia.

Chapter III

METHODOLOGY

Most of the research that has explored moral distress among nurses has looked at nurses working in critical care settings and nurses in the Northeast, Midwest, and Western United States. Few studies were conducted in the southern U.S., and no published studies were found that explored moral distress among registered nurses in Georgia. Moral distress is a poorly understood phenomenon with nurses and a construct frequently unfamiliar to them.

This chapter describes the type of research design and the sample population which was recruited for this study. The instruments used to collect the data and the procedures for data collection are discussed. Ethical concerns regarding research participants are addressed. Lastly, the statistical procedure is explained.

Research Design

A mixed method design was used to: (1) report the frequency and intensity of responses from a 21 item survey, (2) describe the responses to open-ended questions, and (3) determine statistical differences in turnover of nurses experiencing different levels of moral distress. Polit and Beck (2008) define mixed method research as “research in which both quantitative and qualitative data are collected and analyzed” (p. 758). This design fits well with the purpose of the study, which was to obtain a general overview of

Moral distress among RNs working in health care in Georgia, determine the prevalence of nurses who have either left or intend to leave a position due to moral distress, and examine the relationship between moral distress levels and nurse turnover.

Potential threats to internal and external validity were examined. Polit and Beck (2008) define internal validity as “the degree to which it is possible to make an inference that the independent variable is truly causing or influencing the dependent variable and that the relationship between the two is not the spurious effect of a confounding variable” (p. 295). Potential threats to internal validity for this study included: (1) Instrumentation effects – the lack of documented reliability and validity of the instrument used to measure moral distress may impact the ability to translate the findings into constructs. The use of online administration may have impacted the way individuals responded. (2) Selection effects which can also impact internal validity – the biases that are represented in the sample may have impacted the way participants responded, and their responses may be measures of something other than moral distress.

Polit and Beck (2008) define external validity as the “degree to which the study results can be generalized to settings or samples other than the one studied” (p. 753). Potential threats to external validity for this study included: (1) Selection effects – the use of convenience sampling in this study increased the likelihood that that some characteristic of those who self presented or were “accidentally” chosen to participate impacted their responses and made them not representative of the population of nurses in general; (2) Time and historical effects – data were collected at only in one point in time. There might have been conditions or influences which impacted a participant’s responses to questions about moral distress, such as moral or ethical issues in the local or national

news. What is considered an ethical issue for nurses may also have been impacted by recent publications such as the Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health* (2011). The influence of such information may cause nurses to consider their uncomfortable feelings at work are related to other power issues rather than moral distress.

Participants

The group recruited for participation in this study was a convenience sample of RNs working in health care in Georgia. Polit and Beck (2008) define convenience sampling as “selection of the most readily available persons as participants in a study” (p. 750). Study inclusion criteria consisted of RNs who are licensed to practice and work in the state of Georgia, whose age is greater than 18 years, and who had access to the Internet. Invitations to participate were offered through face-to-face contact, the social media website Facebook (www.facebook.com), and by contacting administrators of area hospitals and a long term care facility. Snowball sampling also occurred as participating nurses recruited other nurses. Snowball sampling is defined by Polit and Beck (2008) as the “selection of participants through referrals from earlier participants” (p. 766). A sample size of 100-150 volunteers was sought to provide a representative cross-section of RNs in Georgia. There were originally 180 participants but 18 surveys were incomplete, leaving 162 RNs in the final sample.

Participants in this study consisted of a convenience sample of 162 RNs working in health care in Georgia. The majority of participants in this study was female (92%), Caucasian (88.3%), and had a mean age of 43.97 years. Most were either bachelor’s or science degree in nursing (40.7%) or associate degree in nursing graduates (30.2%).

Participants had a wide range of nursing practice experience from less than one year to 55 years. The mean years of nursing practice experience was 17.76 years. Primary practice roles and practice settings of participants varied. They worked in hospitals, long term care, outpatient settings, community health, hospice, and schools and colleges of nursing. The highest percentage of participants worked as staff nurses (49.4%). The percentage of the sample working in non-critical care areas was 78.4%, while 18.5% worked in critical care areas. Forty percent of participants reported receiving 10 hours or less formal ethics education.

Instrumentation

Nursing demographic information was requested at the beginning of the electronic survey. Data were collected regarding age, gender, ethnicity, educational level, practice setting, primary nursing role, years of nursing experience, and hours of ethics education.

The nurse questionnaire of the *MDS-R* (Hamric, 2010) (see Appendix A) was used to measure moral distress and nurse turnover as a result of moral distress. Permission was obtained from the developer of the instrument, Dr. Ann Hamric, to use the instrument in this study (see Appendix B), as well as to add the phrase “due to moral distress” to clarify the last open-ended question on the survey (see Appendix C).

Dr. Hamric’s first revision of Corley’s *MDS* (2005) was developed in 2007 to study perspectives on end-of-life care in intensive care unit (ICU) settings with 196 critical care nurses and 29 physicians who admitted patients to ICUs. Hamric first reduced Corley’s original 38-item *MDS* (Corley, 2005) to 21 items, and finally to 19 items. The *MDS-R* was further revised and now includes 21 clinical situations which may

or may not be disturbing to nurses. The situations deal with aggressive end-of-life care, incompetent care, institutional constraints, deception of patients, inadequate pain management, and ignoring patient autonomy. The instrument is constructed in a 5-point Likert format. Participants rate both the frequency and the intensity of the moral distress each situation causes. The scale is a scale from 0 (never occurred/not distressing) to 4 (occurred very frequently/greatly distressing). There is also a space which allows participants to list and score “other” situations in which they experienced moral distress. Hamric says these were added to identify more root causes of moral distress (A. B. Hamric, March 22, 2011, personal communication). At the end of the survey, questions are asked regarding leaving or considering leaving a past position due to moral distress, and whether the respondent is considering leaving their current position due to moral distress.

Dr. Hamric devised a scoring method to generate a composite score for the current level of moral distress, which she asserts is useful in multivariate analyses (A. B. Hamric, March 22, 2011, personal communication). For each item, the frequency score and intensity (named “level of disturbance”) score are multiplied. This product can range from 0 to 16. The products of the 21 situations are added to obtain the composite moral distress score. Hamric asserts that this composite scoring scheme allows all items marked as never experienced or not distressing to be eliminated from the score, giving a more accurate reflection of actual moral distress. The resulting score based on the 21 items has a range of 0 to 336 (A. B. Hamric, March 22, 2011, personal communication).

Hamric has since developed six versions of the *MDS-R*: nurse, physician, and other healthcare versions for adult care settings, and a nurse, physician, and other

healthcare versions for pediatric settings. For this study, the *MDS-R* instrument developed for nurses working in adult care settings was used.

Hamric's instrument (*MDS-R*) was tested for content validity by four nurse experts on moral distress. Content reviewers independently coded the primary and secondary root causes of moral distress reflected in each revised item. Results show 88% (19 of 21 items) interrater agreement on primary and secondary root causes of moral distress reflected in each item (A. B. Hamric, March 22, 2011, personal communication).

The instrument has recently undergone pilot testing for reliability and construct validity. The *MDS-R* was tested in eight ICUs (six adult and two pediatric) at one institution with physicians and RNs. Cronbach alpha internal consistency reliability of the 21-item *MDS-R* was .88 (physicians = .67 [.69 for attending physicians]; RNs = .89) (A. B. Hamric, March 22, 2011, personal communication). The normal range of values is between .00 and 1.00, with higher values reflecting a higher internal consistency. A value of .70 or higher is considered "acceptable" in social science research (Polit & Beck, 2008, p. 455).

In testing for construct validity, four hypotheses were tested based on earlier findings from the literature. All were significant in the expected directions. Moral distress was negatively correlated with ethical climate ($r = -0.415, p < .001$). *MDS-R* scores were significantly higher for those clinicians considering leaving their positions ($p < .001$). Nurses with more experience had higher moral distress ($r = .17, p = .037$) (A. B. Hamric, March 22, 2011, personal communication).

Procedures

After approval was obtained through Valdosta State University's Institutional

Review Board (see Appendix D), the survey was posted on SurveyMonkey (www.surveymonkey.com); an online, password protected survey service. Demographic information was requested from participants at the beginning of the online survey regarding age, gender, ethnicity, level of education, primary nursing role, current practice setting, years of practice as a nurse, and amount of prior ethics education (see Appendix E). Questions from the *MDS-R* followed the demographic questions. Two colleagues were enlisted to pilot-test the on-line survey to uncover errors in posting and to determine any difficulties in accessing and completing the survey.

In order to ensure an adequate sample for the study, I used numerous recruitment techniques to elicit participation by Georgia RNs in a variety of practice settings. Direct requests, as well as snowball sampling, were used to enlist participants. One study participant would frequently share the survey link with another potential participant directly or through social media. Further, nursing administrators were contacted at six area hospitals and two long-term care facilities to gain permission to approach RNs employed at the facilities to elicit their participation in the study.

Administrators at three hospitals and one long-term care facility agreed to allow information regarding the study to be distributed to their RN staff (see Appendix F). Nurses were recruited using the best recommended method preferred by administrators. Participating facilities were provided with invitation post cards (see Appendix G), survey announcement flyers (see Appendix H), and e-mail invitational letters (see Appendix I) to preview before making their decisions. All documents contained details of the study, confidentiality of results, eligibility criteria, emphasis that participation was voluntary, researcher contact information, and an electronic link to the survey. Some facilities

preferred to post the survey announcement flyer, some informed RNs about the survey at their staff meetings, and others elected to send out electronic invitational letters to the RNs in their facilities using their intranet systems.

Additional participants were recruited by visiting the Georgia Nurses Association (GNA) website and finding contact information for chairpersons of local GNA chapters to further expand contact to RNs in Georgia. Requests were e-mailed to those chairpersons to contact their members, attaching study documents for their review. Five chapter chairpersons agreed to send the electronic survey invitation to chapter members. The chairperson of a north Georgia American Association of Nephrology Nurses (ANNA) chapter was also contacted via e-mail to elicit participation of the organization's members in the survey.

Master's degree students and RN-to-BSN students currently and previously enrolled in Valdosta State University's College of Nursing were invited to participate in the survey using university e-mail and personal contact. Two nursing professors at Georgia Southern University were contacted and agreed to send the invitation and information regarding the study to their colleagues. Besides word of mouth and e-mails, an invitation was posted to participate in the survey on the social media site, Facebook, to contact Georgia RNs. Survey postcards were also distributed to RNs at a local *Relay for Life* event. Finally, a survey invitation flyer was posted in a local uniform shop.

Participants completed surveys via an electronic, password protected questionnaire format using SurveyMonkey, an online survey service. The survey was available online for five weeks.

The survey included questions regarding the demographic characteristics of the sample. Questions from the nurse questionnaire of the *MDS-R* were presented which measures the intensity and frequency of moral distress and asks if moral distress is a reason for having left or having considered leaving a nursing position.

Participants were surveyed for frequency of occurrence and intensity of clinical situations occurring in their nursing practices which may cause moral distress. They were given the opportunity to report and score for frequency and intensity any other morally distressing situations in their practices. Composite moral distress scores were calculated based on the participants' frequency and intensity scores on the clinical situations. Finally, nurses were asked if they had left or considered leaving a nursing position due to moral distress.

Ethical Considerations

Permission was obtained from three hospitals and one long-term care facility to elicit participation from the RNs working in their facilities (see Appendix F). An e-mail address and phone number were supplied in all recruitment materials for participants to contact should they have any questions. Written consent was not obtained from participants because this study did not require experimental treatments or interventions and, therefore, there was no anticipated potential for harm to participants. Participation was voluntary and anonymous. No information was requested identifying participants or their workplaces. The surveys were completed through a password-protected online survey site. There was no face-to-face contact made during data collection. These measures were taken to assure confidentiality for the participants completing the surveys and confidentiality for the organizations where the moral distress experiences may have

occurred. Participants were informed that they could withdraw from the survey at any time and that participation in the survey implied consent.

Statistical data from this study was sent to the developer of the instrument (Dr. Hamric), to help establish additional psychometric data for the scale as a condition for using the survey instrument. Participants were informed that completion of the on-line questionnaire implied consent to forward research results to Dr. Hamric. Participants were assured that all information would remain confidential.

Data Analysis

Mean moral distress frequency and intensity scores were calculated for each clinical situation. The clinical moral distress situations were ranked in order of mean frequency and intensity scores.

A composite moral distress score was calculated for each participant by multiplying the frequency score by the intensity score for each situation and adding the products of the 21 situations. A mean moral distress composite score and standard deviation was calculated for the sample. For this study, Statistical Package of Social Science (SPSS) software Version, 17.0 (IBM Corporation, Armonk, NY) was used to determine if there was a relationship between composite moral distress scores (levels) and nurse turnover.

There was one open-ended question on the survey instrument asking for further descriptions by participants of clinical situations in which they experienced moral distress. Content analysis was used to analyze themes from the participants' points of view. Responses to this qualitative question were first coded and categorized using line-

by-line analysis. Data were then coded further and re-categorized into major underlying theoretical themes.

The final questions on the survey examined whether moral distress had caused the participants to leave, or consider leaving, a previous job. Additionally, participants were asked if they were considering leaving their present job due to moral distress. Responses to these questions were reported as percentages of the sample choosing each response.

Summary

After approval from Valdosta State University's Institutional Review Board and participating organizations, mixed method research was conducted using a convenience sample of RNs working in multiple practice settings in Georgia. Data were collected using the nurse questionnaire of the *MDS-R*, developed by Dr. Ann Hamric (2010). Participants were assured of confidentiality and informed that participation was voluntary. The online survey was completed via the Internet at SurveyMonkey.com. After five weeks, the quantitative and qualitative data were analyzed. Results of the data analysis are reported in the Chapter IV.

Chapter IV

RESULTS

The purpose of this study was to explore the levels of moral distress among RNs working in various practice areas of health care in Georgia to determine if moral distress is a reason for nurses to leave or consider leaving their nursing positions. Frequencies and intensities of distress were examined with situations found in prior research to be responsible for triggering moral distress. This research also sought to determine if moral distress was a reason for nurse turnover among RNs working in health care in Georgia. Finally, the composite moral distress levels of RNs were examined to determine if any there were any differences among those who: (a) left a position, (b) considered leaving a position, and (c) never considered nor left a position.

This mixed-method study recruited a convenience sample of 162 RNs working in multiple practice settings in health care in Georgia to complete an online survey. The survey included questions regarding the demographic characteristics of the sample and questions from the nurse questionnaire of the *MDS-R* which measures the intensity and frequency of moral distress and asks if moral distress is a reason for having left, or having considered leaving, a nursing position. After participants scored the clinical situations for frequency and intensity, they were asked an open-ended question related to moral distress in which they had an opportunity to describe clinical situations which had caused them particular moral distress, yielding qualitative data.

The participants' frequency and intensity scores for the clinical situations were reviewed. Participants' descriptions of other morally distressing situations in their practices were analyzed. The qualitative data were subjected to content analysis to elicit themes from the participants' points of view. Composite moral distress scores were calculated for participants. A mean composite moral distress score and measure of central tendency was calculated for the group. Finally, a statistical analysis was done to see if there is a difference in moral distress among RNs who: (a) left a position, (b) considered leaving a position, and (c) neither considered nor left a position.

Research Questions

The survey asked participants to score 21 clinical situations for frequency and level of disturbance (intensity) using a Likert format. Participants were also asked an open-ended question related to moral distress in which they had an opportunity to describe clinical situations which had caused them particular moral distress.

Research Question One. "What clinical situations of moral distress are experienced most frequently among RNs working in health care in Georgia?" The mean frequency scores of the 21 clinical situations in order from highest to lowest are reported in Appendix J. The top 10 clinical situations generating the highest frequency scores are listed in Table 1. The clinical situation with the highest mean frequency score was: "Carry out the physician's orders for what I consider to be unnecessary tests and treatments" ($M = 2.33$ on a scale of 0 to 4). The item with the lowest mean frequency score was: "Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death" ($M = 0.38$ on a scale of 0 to 4).

Table 1.

Mean Item Scores for Frequency

Clinical Situations	Frequency Ratings (on a scale of 0 to 4)
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	2.33
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	2.10
Initiate extensive life-saving actions when I think they only prolong death.	1.99
Witness diminished patient care quality due to poor team communication.	1.71
Watch patient care suffer because of a lack of provider continuity.	1.68
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	1.67
Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	1.53
Work with levels of nurse or other care provider staffing that I consider unsafe.	1.45
Witness healthcare providers giving "false hope" to a patient or family.	1.44
Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	1.41

Research Question Two. “What clinical situations lead to the highest intensity of moral distress among RNs working in health care in Georgia?” The mean intensity scores of the 21 clinical situations in order from highest to lowest are reported in Appendix K. The top ten clinical situations generating the highest intensity scores are listed in Table 2. The clinical situation with the highest mean intensity score was: “Work with levels of nurse or other care provider staffing that I consider unsafe” ($M = 3.4$ on a scale of 0 to 4). The clinical situation with the lowest mean intensity score was: “Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death” ($M = 2.57$ on a scale of 0 to 4).

Survey Narrative Analysis

Research question two includes a qualitative component. Participants were asked an open-ended question related to moral distress in which they had an opportunity to describe clinical situations which had caused them particular moral distress. The narratives from the participants’ descriptions of other morally distressing situations were analyzed. Content analysis was used to identify themes from the participant’s point of view. Responses to the qualitative question were first coded and categorized using line-by-line analysis. Data were further coded and re-categorized into major underlying theoretical themes. The six themes which emerged were: (1) falsification/deception; (2) beliefs/personal values; (3) safety/care inadequacies; (4) relationships with colleagues; (5) unnecessary or futile care; and (6) care coordination.

Falsification and Deception. Participants expressed moral distress at being asked to falsify staffing level records. They were troubled when witnessing providers changing chart information after the fact, or charting assessments and education that were not done.

Table 2.

Mean Item Scores for Level of Disturbance (Intensity)

Clinical Situations	Intensity Ratings (on a scale of 0 to 4)
Work with levels of nurse or other care provider staffing that I consider unsafe.	3.40
Assist a physician who, in my opinion, is providing incompetent care.	3.37
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	3.31
Be required to care for patients I don't feel qualified to care for.	3.27
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	3.22
Witness diminished patient care quality due to poor team communication.	3.19
Watch patient care suffer because of a lack of provider continuity.	3.17
Witness medical students perform painful procedures on patients solely to increase their skill.	3.16
Ignore situations in which patients have not been given adequate information to insure informed consent.	3.11
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	3.10

“I have witnessed medical personnel - nurses and physicians- going to the Medical Records Department, checking out charts, and changing chart information - after the fact!!”

“Being asked to falsify staffing levels.”

“Nurses who chart assessments and education that were not done.”

Beliefs/Personal Values. Participants experienced moral distress due to situations in which their beliefs and personal values were challenged. They related conflict in response to abortion issues, whether patients deserved Medicaid benefits or not, lack of commitment to care by co-workers, and the frustration they felt from being unable to provide ideal care under current conditions.

“Continuing to provide Medicaid paid services for clients who knowingly are involved in illegal activities.”

“Witness poor patient care quality due to staff’s laziness and lack of concern for quality patient outcomes.”

“The patient understood what the administration of this drug would do and she completely agreed with the final decision. However, several nurses on my floor refused to administer this medication because they believed that it went against their moral codes of conduct. Being a nurse that supports a woman's right to choose in an area where this is typically frowned upon, I had a major decision to make. Do I advocate for my patient? Doing so would certainly alienate me from the rest of my coworkers. I felt as though following through with her (patient’s) wishes and the doctor's orders was not only my obligation as a nurse but also my

moral obligation. This situation caused moral distress for every person involved, and it is certainly not something I will soon forget.”

Unsafe or Inadequate Care. Participants voiced moral distress in response to situations involving issues with safe and adequate care. The situations included being pressured to working unsafe (extended) hours, inadequate staffing, incompetence of staff members including nurses and physicians, being mandated to float to areas where they felt inexperienced, physicians failing to provide patients with information about their condition, ignoring patient needs and/or requests.

“When an event occurs that could cause harm but does not, it is not addressed because there was no adverse event.”

“Floated to an area without experience in caring for those type patients”

“Experiencing pressure by physicians to require staff to work hours beyond what is reasonably safe for non-emergent scheduled procedures and having the process or rule which was in place to prevent this suspended by administration.”

“Physician ignoring a patient's request for a DNR after he (patient) clearly and coherently asked for no extreme measures to be taken to prolong his life.”

Relationships with Colleagues. Participants in the study expressed moral distress in response to situations which involved relationships with colleagues. Those situations included downright bullying by doctors and supervisors, alienation from co-workers, game-playing, staff's lack of concern for quality patient outcomes, dilemmas about reporting observed abuse or unsafe actions of colleagues.

“Communication or lack thereof between the providers; physicians, nurses, etc., and workplace incivility as a result...LEVEL 10 to the tenth power!”

“Being aware of questionable actions of a co-worker and not reporting it due to other co-workers.”

“Great moral distress when I learn of unethical issues from other departments that have been reported up the chain of command yet no accountability ensues.”

“Working with doctors that harass you without any repercussion to them. Belittle you and talk down to you.”

Unnecessary or Futile Care. Participants identified futile lifesaving measures, unnecessary patient admissions, and wasting resources by conducting unnecessary patient testing as sources of moral distress.

“Families refuse to terminate care in hopeless situations because they want/need the patient's "check" to continue coming in for financial support/gain. This is actually verbalized by the family member(s).”

“Do life saving measures on very old person (92) who has been in nursing home for years and family says they have not lived their lives....”

“Doing EKG's on people who are dead; doing urine drug screens on patients daily; doing x-rays and CT's daily on patients.”

“Continuing to offer chemotherapy regimens one right after the other when it is obvious that there is progression and no other chemo will be beneficial.”

Care Coordination. Participants spoke of experiencing moral distress in response to fragmented and uncoordinated care. For example, physicians only gave care connected with their specialty area, rather than seeing the patient as a whole. They expressed complaints about staff members delaying patient transfers in order to avoid having an extra admission on their particular shift. They thought leaders ignored this type of game-playing. There was irritation expressed about the unavailability of needed supplies and medications and how the nurse would chronically end up being the scapegoat in such circumstances.

“I find it is getting harder and harder to function like a professional nurse and to adequately care for my patients when on a lot of occasions the right supplies aren't available or the medications aren't available, etc. The nurse is the one that takes the blow for these kinds of things. I feel like I'm a wonderful nurse but then those things just shoot my good intentions to the ground and my patient suffers.”

“Low staffing, poor workflow, different units or departments hold onto a patient and do not transfer to avoid getting another admission personally, then the general units are overwhelmed at shift change and handoff is unsafe.”

“Physicians not providing holistic care--only concerned about their specialty and not addressing the mental needs.”

“The things that cause the most moral distress on our floor is the continuity of care between doctors, we have different doctors on the case from week to week who sometimes don't understand what their plan for the patient is, try to order tests that have already been run and have a different opinion on how to care for the patient, which confuses the patient and family and makes it really hard on the nurses.”

Research Question Three. “What is the composite level of moral distress among RNs working in health care in Georgia?” The level of moral distress is represented by the composite score on the *MDS-R* (A. B. Hamric, March 22, 2011, personal communication). The frequency and intensity scores of each of the 21 individual situations were multiplied and the products added to obtain a composite score of moral distress for each participant. The resulting scores based on these 21 items have a possible range from 0 to 336. Since 38 participants failed to score all clinical situations for frequency and intensity, composite scores were calculated for 124 participants. Following this revision, the composite scores of the group ranged from 4.00 to 268. The mean *MDS-R* composite score for the group was 83.00 ($SD = 46.78$).

Research Question Four. “What is the prevalence of nurse turnover or intent to turnover due to moral distress among RNs working in health care in Georgia?” There were two questions on the survey pertaining to nurse turnover due to moral distress. The two questions were:

1. Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

2. Are you considering leaving your position now because of your moral distress with the way patient care is handled at your institution?

Of 154 survey participants who answered question one, 40.9% ($n = 63$) had never considered quitting or left a position, 31.8% ($n = 49$) considered quitting but did not leave, and 27.9% ($n = 43$) left a position due to moral distress. Of 152 survey participants who answered question two, 13.2% ($n = 42$) are considering leaving their current position as result of moral distress resulting from the way patient care is handled at their institution, while 86.8 % ($n = 132$) reported they are not.

Research Question Five. “Is there a difference in moral distress among RNs who: (a) left a position; (b) considered leaving a position; and (c) neither considered nor left a position? A one-way between subjects analysis of variance (ANOVA) was conducted to determine the relationship between moral distress of RNs and nurse turnover. Alpha was set at .05. The omnibus F test revealed that the three means were not equal, $F(2, 121) = 11.26, p < .001$. The effect size was $hp^2 = .16$. The Tukey adjustment was used to control for Type I error for paired comparisons. The mean composite moral distress score of RNs who left a position due to moral distress ($M = 92.59, SD = 50.32$) was statistically higher ($p = .002$) than the mean score of RNs who neither considered nor left a position due to moral distress ($M = 58.84, SD = 38.77$). The mean composite moral distress score of RNs who considered leaving a position due to moral distress (but stayed) ($M = 100.31, SD = 41.21$) was statistically higher ($p < .001$) than the mean score of RNs who neither considered nor left a position due to moral distress. Statistical analysis showed no significant difference ($p = .710$) between the mean composite moral distress score of RNs

who left a position due to moral distress and the mean score of RNs who considered leaving a position due to moral distress (but stayed) (see Figure 2).

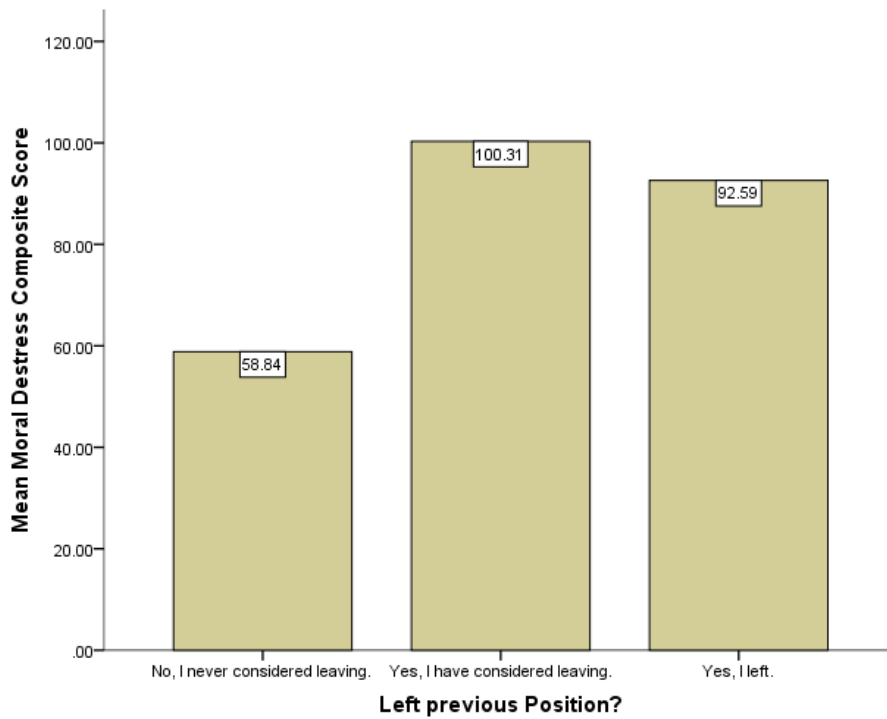


Figure 2. Mean Composite Moral Distress Scores and Nurse Turnover.

Summary

The nurse questionnaire of the *Moral Distress Scale-Revised* (2010) was used to measure the intensity and frequency of morally distressing situations occurring in clinical situations among RNs working in various practice areas of health care in Georgia. The clinical situation with the highest mean frequency score involved carrying out physicians' orders for what participants perceived as unnecessary tests and treatments. The clinical situation with the highest mean intensity score involved working with levels of nurse or other care provider staffing considered by the participants as unsafe.

Composites scores representing the levels of moral distress among participants were calculated from the intensity and frequency ratings of clinical situations.

The research examined moral distress to determine if it was a reason for nurses to leave or consider leaving their nursing positions. Among the participants in this study, 27.9% left a position due to moral distress, 31.8% considered quitting but did not leave, and 13.2% are considering leaving their current position because of moral distress with the way patient care is handled at their institution. Finally, RNs' moral distress levels (composite moral distress scores) were analyzed with their responses to turnover questions. RNs who considered leaving or left positions due to moral distress had statistically higher moral distress levels than those who neither considered leaving nor left positions due to moral distress.

Chapter V

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

In this chapter, findings will be evaluated against the backdrop of the previous literature and the five research questions. Theoretical implications, limitations, strategies for addressing moral distress and recommendations for further research will be discussed. Recommendations for nurse and health care administrators, individual nurses and nurse educators will be offered.

The purpose of this study was to explore the intensity and frequency of moral distress among registered nurses (RNs) working in health care in Georgia to see if moral distress was a reason for nurses to leave or consider leaving their nursing positions. The five research questions asked in this study were:

1. What clinical situations of moral distress are experienced most frequently among RNs working in health care in Georgia?
2. What clinical situations lead to the highest intensity of moral distress among RNs working in health care in Georgia?
3. What is the composite level of moral distress among RNs working in health care in Georgia?
4. What is the prevalence of nurse turnover or intent to turnover due to moral distress among RNs working in health care in Georgia?

5. Is there a difference in moral distress among RNs who: (a) left a position; (b) considered leaving a position; and (c) neither considered nor left a position?

Discussion of Research Questions

Research question number one was, “What clinical situations of moral distress are experienced most frequently among RNs working in health care in Georgia?” The clinical situation most frequently experienced by nurses was “carrying out the physician’s orders for what I consider to be unnecessary tests and treatments” (frequency score = 2.33 on a scale of 0 to 4). Second in frequency was a description of futile care, “following the family’s wishes to continue life support even though I believe it is not in the best interest of the patient” (frequency score = 2.10 on a scale of 0 to 4). These results correspond to previous studies of nurse moral distress and demonstrate that this sample of Georgia RNs is not unique in their experiences with moral distress. Nurses surveyed in Rice et al. (2008) research reported the highest encounter frequencies to the clinical situation, “Follow the family’s wishes to continue life support even though it is not in the best interest of the patient.” This clinical situation received high frequency scores in research reported by Corley (1995) (5.5 on a scale of 0 to 7) and Zuzelo (2007) (2.86 on a scale of 0 to 6). “Carry out a physician’s order for unnecessary tests and treatment” also received high frequency scores in research reported by Corley (1995) (5.8 on a scale of 0 to 7), Zuzelo’s (2007) (3.31 on a scale of 0 to 6), and Pauly et al. (2.55 on a scale of 0 to 6).

Research question number two posed, “What clinical situations lead to the highest intensity of moral distress among RNs working in health care in Georgia?” Working with unsafe staffing levels of nurses or other care providers received the highest intensity score (3.40 on a scale of 0 to 4) among participants. The situation which received the next

highest intensity score (3.37 on a scale of 0 to 4) was assisting “a physician who, in my opinion, is providing incompetent care.” To “take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing,” followed closely in intensity with a score of 3.31 on a scale of 0 to 4. These findings were consistent with those of previous studies and are of concern for health care outcomes in Georgia. Unsafe staffing levels received high intensity moral distress scores in research reported by Corley et al. (2001) (5.47 on a scale of 0 to 7); Pauley et al. (2007) (4.63 on a scale of 0 to 6); and Zuzelo (2007) (4.14 on a scale of 0 to 6). Assisting physicians perceived as incompetent also received high intensity moral distress scores in research reported by Corley et al. (2001) (5.34 on a scale of 0 to 7); Pauley et al. (2007) (4.44 on a scale of 0 to 6); and Zuzelo (2007) (3.95 on a scale of 0 to 6).

It is noteworthy that the clinical situations that evoked the most intense moral feelings were not the ones that occurred most frequently. Most frequent were unnecessary testing and futile care; none of which were on the top ten of most distressing clinical situations. Most distressing clinical situations were unsafe staffing levels, (first) incompetent care (second, fourth, and fifth in intensity), and being asked by someone in authority not to take action when an ethical issue occurred (third in intensity).

Research question two includes a qualitative component. Participants were asked an open-ended question related to moral distress in which they had an opportunity to describe clinical situations which had caused them particular moral distress. Six themes which emerged from the data were: (a) falsification/deception, such as falsifying patient records and administrative reports and doctors charting they saw the patient when they

did not; (b) beliefs/personal values that come into conflict in clinical situations such as whether or not to treat medically indigent patients or to assist with an abortion of a fetus with multiple serious defects; (c) safety/care inadequacies like suboptimal care due to unsafe staffing, using system workarounds, incompetent providers and working unsafe hours; (d) relationships with colleagues such as one RN who reported “being aware of questionable actions of a colleague and not reporting it due to other co-worker pressures” and an RN who felt “alienated by co-workers” and another who was “bullied by doctors and supervisors;” (e) unnecessary or futile care such as the RN who wrote about “lifesaving measures on a very old (92 years old) person” and “doing EKG’s on people who are dead;” and (f) lack of care coordination such as the RN who wrote: “It is getting harder and harder to function like a professional nurse and to adequately care for my patients when on a lot of occasions the right supplies aren’t available and the right medications aren’t available, etc. The nurse is the one that takes the blow for these kinds of things. That to me is my biggest stress right now. I feel like I’m a wonderful nurse but then those things just shoot my good intentions to the ground and my patient suffers.”

Themes identified in the qualitative data in my research were consistent with themes found in prior moral distress qualitative research. Torjuul and Sorlie (2006) reported similar themes, such as difficulties with heavy workloads and lack of time, which compromised the quality of care nurses were able to deliver. Participants reported distress resulting from the deception of patients and families, futile care, the lack of holistic care for patients, and the inability to administer care according to their beliefs (Torjuul & Sorlie, 2006). Wilkinson (1988) reported that nurses’ moral decisions were

constrained by physicians, nursing administrators, and institutional policies. Moreover, nurses described receiving little support from physicians or administration with moral issues. These comments were consistent with those expressed by participants in the present study.

In their comments, Georgia RNs expressed dismay at being unable to adequately advocate for their patients because of internal and external constraints. Common external constraints include inadequate staffing, hierarchies within the health care system, lack of collegial relationships, lack of administrative support, policies and priorities conflicting with care needs, pressure to reduce costs and fear of litigation. Internal constraints were found to be of a more personal nature and included: lack of assertiveness, self-doubt, perceived powerlessness, and socialization to follow orders.

Differences in roles and positional power between physicians and nurses, administrators and nurses, and nurse leaders and nurses in healthcare organizations are responsible for authority differences which can repress personal values of nurses. These differences may create a steep authority gradient which can influence both patient care and organizational decisions by repressing those in subordinate positions (in many cases nurses), keeping them from influencing or making decisions they consider to be the most appropriate (Edmonson, 2010). Frustration due to this organizational power hierarchy was evident in participants' comments below.

“Working with Doctors that harass you without any repercussion to them.

(They) belittle you and talk down to you.”

“Distress about challenging substandard standards of care.”

“Experiencing pressure by physicians to require staff to work hours beyond what is reasonably safe for non-emergent scheduled procedures.”

The RNs reported being bullied by supervisors and physicians, but did not elaborate with specific examples. The RNs expressed a reluctance to act on their ethical decisions for fear of retribution from co-workers, supervisors, and physicians, but did not say what retribution they expected. RNs expressed dissatisfaction with the failure of nursing and upper level management to address ethical issues.

Research question number three posed, “What is the composite level of moral distress among RNs working in health care in Georgia?” The level of moral distress is represented by the composite score (representing both frequency and intensity) on the *MDS-R* (A. B. Hamric, March 22, 2011, personal communication). The mean *MDS-R* composite score for the sample was 83.00 ($SD = 46.78$; $Range = 4.00$ to 268).

The developer of the instrument, Dr. Hamric, was contacted to see if there is a theoretical or conceptual definition of what the scores mean in terms of relative distress. Dr. Hamric says that there is no way to define the “meaning” of the score because this is a new scale. She asserts that higher scores are correlated with higher levels of moral distress, but insufficient data has been collected to associate specific scores with levels of distress. Until more data is obtained, only comparative meaning can be assigned to the scores. (A. B. Hamric, November 7, 2011, personal communication).

The mean composite moral distress score for the nurses sampled in the present research is consistent with those mean composite scores reported by Hamric & Blackhall (2007) from two samples of critical care nurses (80.38 and 70.21) and a pilot test of the *MDS-R* with critical care nurses that resulted in a mean composite moral distress score of

92.85 (*range* = 3.00 to 256) (A. B. Hamric, March 22, 2011, personal communication). Hamric et al. (2011) report a mean composite moral distress score of 91.53 (*SD* = 44.24, *range* = 3 to 256) for nurses participating in a recent study testing the *MDS-R*. The mean composite moral distress score of 83.00 for participants in the present study, the largest percentage (78.4%) of whom worked in non-critical care areas, was similar to results obtained in testing the *MDS-R* with critical care nurses (Hamric & Blackhall, 2007; Hamric et al., 2011). This result implies that nurses working outside critical care areas experience moral distress at levels similar to critical care nurses.

Research question number four posed, “What is the prevalence of nurse turnover or intent to turnover due to moral distress among RNs working in health care in Georgia?” Among the sample of Georgia RNs, 27.9% reported they had left a position due to moral distress and 31.8% considered quitting, but did not leave. Of those completing the survey, 13.2% reported they are contemplating leaving their current position due to moral distress. Corley (1995) and Corley et al. (2005) reported 12% and 25.5% of nurses, respectively, had left a position in the past due to moral distress. Hamric and Blackhall (2007) reported that 17% of nurses had left a position and 28% had considered leaving due to moral distress. Cavaliere et al. (2010) reported that 4.3% of neonatal intensive care RNs left a previous position due to moral distress, 30.9% said they had considered leaving but did not do so, and 10.6% reported an intention to leave their current positions due to moral distress. Winland-Brown et al. (2010) reported 22% of the RNs had left a position due to moral distress and 26.2% had considered leaving but did not do so. Moral distress is a clearly a factor in nurse turnover in the present study of

Georgia RNs. However, because the population of RNs was a convenience sample, the data cannot be generalized to all RNs in Georgia.

Research question number five asked, “Is there a difference in moral distress among RNs who: (a) left a position; (b) considered leaving a position; and (c) neither considered nor left a position? Data revealed that RNs who neither considered leaving nor left their positions experienced significantly less moral distress than those who left or considered leaving. This is an important finding which relates directly to nurse retention in health care organizations. More research is needed to obtain a clearer picture of what RNs mean when they state they left a position due to moral distress. Moral distress in this study encompassed many different clinical situations and the term can mean different things to different nurses. Since moral distress is a broad, inclusive term, more studies are needed to determine the exact reasons nurses leave. Conflicts with certain persons, unavailability of supplies, recurrent understaffing, working conditions that threaten licensure, and numerous other clinical situations could be classified as moral distress. Further exploration into reasons why nurses left or are considering leaving their positions will point to strategies needed to address moral distress.

Having nurses who are morally content and who plan to remain in their positions is desirable for many reasons. There are high human and financial costs associated with nurse turnover including recruitment, orientation and training (Cavaliere et al., 2010; PricewaterhouseCoopers’ Health Research Institute, 2007). Nurse turnover compounds the existing crisis of critical nurse shortages. Hospitals with higher turnover rates have higher costs per patient stay (Kosel & Olivo, 2002). Nurse turnover effects staffing levels which in turn effects patient care outcomes (Aiken et al., 2002; Ke-Ping Yang, 2003).

Theoretical Implications

The theoretical framework used for this study was Corley's (2002) theory of moral distress. Corley maintains that it is the inability of nurses to act according to their moral convictions, and thus preserve their moral integrity, which leads to moral distress. Corley's theoretical model displays a pathway for managing moral distress and developing moral competency. Corley's model demonstrates consequences of not attending to moral distress.

According to Corley's (2002) theory, moral distress negatively affects patients, nurses, and the health care organization. Corley describes the impact on nurses as suffering which leads to burn-out, turnover, or leaving the nursing profession. This premise is supported by the percentage of Georgia RNs with moral distress who reported leaving or who considered leaving a nursing position. Some participants' qualitative responses indicated that their experiences with moral distress occurred in previous jobs rather than in their current jobs. The degree of suffering of nurses was evident in their qualitative responses when they used phrases such as "level 10 to the tenth power!" and wanted to rate their situations higher than the MDS-R instrument allowed.

Corley's (2002) model details the impact of moral distress on patients as increased suffering as a result of a lack of advocacy by nurses. Moral distress can result in patients' increased pain, extended length of hospital stay, and patient care that is less than ideal. Participants in this study noted incidences of inadequate patient care, patient safety concerns, and ignoring patients' wishes when making treatment decisions.

Corley's (2002) model describes several results of moral distress that impact health care organizations. High nurse turnover, decreased quality of care, and low patient

satisfaction leads to problems with reputation, recruitment, and accreditation. Turnover due to moral distress was reported by RNs in this study. Thirty-one per cent (49) considered quitting but did not leave, and 27.9% (43) left a prior position due to moral distress. According to Corley's model these levels of turnover are costly in both human and economic terms.

Study Conclusions

Nurses who reported they "never considered leaving" their positions experienced significantly less moral distress than those who "considered leaving" and those who "left" prior positions. This finding illustrates how nurses who have moral comfort are less likely to leave their position. This supports Corley's (2002) theory of moral distress which implies that nurses who have moral comfort are less likely to burn out, resign from a position or leave nursing. This finding is potentially important for dealing with the current nursing shortage crisis. If health care organizations were to assess moral distress levels of their nurses, it could help with identifying those at risk for leaving. Assessment results might point to strategies that could increase nurse retention.

When participants ranked the clinical situations which gave them the highest intensity of moral distress, working with unsafe staffing levels was of highest concern to Georgia RNs in this study. Their perception that physicians, co-workers, and other providers in the health care setting lacked competence to provide safe and quality care ranked second and fifth in situations which induce higher intensities of moral distress. These clinical situations entail major safety concerns that need to be examined closely by health care organizations if they are to maintain credentialing and remain in business.

Georgia RNs ranked “carrying out physician’s orders for what I consider to be unnecessary tests and treatments” as the most frequently encountered clinical situation that resulted in moral distress. The second and third most frequently encountered clinical situations had to do with futile care. Unnecessary treatment and futile care are moral dilemmas that result in additional costs for health care organizations, many that are already struggling to survive.

The open-ended question in the survey invited more description of situations causing moral distress for the nurses. Those themes corresponded to those found in reviewed prior research and may be used to expand different versions of the tool to measure moral distress for different populations of nurses working in different settings.

Moral distress was cited by 27.9% of participants as a reason for leaving a previous position, while 31.8% considered leaving, but stayed. Of the survey participants, 13.2% are considering leaving their current positions due to moral distress.

Limitations and Lessons Learned

Social media was an expedient method of contacting potential participants for the study. The ability to contact a large number of people in a short amount of time was advantageous in recruitment of participants. Snowball sampling led to recruitment of many of the participants for the study. Nurses tended to respond favorably to the recommendations of their peers to participate in the survey.

Some participants failed to complete the survey for frequency and/or intensity of moral distress, or both. This may have been due to the limited ability to format the survey in SurveyMonkey (www.surveymonkey.com). It was not possible to upload the instrument directly into the web site. The formatting constraint required making two

separate lists of identical questions to acquire the needed scores for frequency and intensity of the clinical situations. This constraint prevented a calculation of a composite moral distress score for 38 participants and prevented their inclusion in analysis of the relationship between composite moral distress scores and turnover due to moral distress. Participants may have been confused about the importance of scoring all items for both frequency and intensity.

There were several limitations to this study of moral distress and its influence on nurse turnover. First, using a convenience sample of volunteer RNs prevented generalization to RNs in Georgia. Second, there was no way to control who participated in the study. Since the survey was only offered on-line and was anonymous, this study relied on the honesty of the participants stating that they were RNs and eligible to complete the survey. Also, snowball sampling (nurses telling other nurses about the survey) was used which may have resulted in ineligible participants completing the survey. Since the survey was web-based, those without access to a computer or without computer expertise would not be able to participate in the study.

The survey instrument itself had limitations. It is a newly developed instrument which is undergoing pilot testing. There is insufficient psychometric data at present to document its reliability and validity.

Suggestions for Further Research

Further research on moral distress is needed to gain a better understanding of the phenomenon. Suggestions for further study include:

1. Qualitative inquiry to examine why nurses make decisions to stay or leave positions and how their decision-making relates to moral distress.

2. Conduct setting-specific studies of moral distress adjusting the survey questions for different practice settings to make them more relevant. For example, nurses in smaller institutions or in outpatient settings may never have contact with medical students, so the question regarding medical students practicing their newly learned skills on patients would not be applicable.
3. Examine resources that nurses use to cope with moral distress to see which ones are effective.
4. Study health issues of nurses who are experiencing or have experienced moral distress.
5. Examine the effect of formal ethics education workshops on nurse moral distress and turnover rates.
6. Examine the hierarchical structures and nurse-physician-management relationships within the hospital environment.
7. Research new nursing models that maximize moral comfort for nurses.

Implications for the Nursing Profession

Georgia RNs in this study experienced moral distress in both frequency and intensity. Nurses experiencing the least moral distress were more likely to state they planned to stay in their present positions. Moral distress is influencing nurses to leave positions in the midst of the present nursing shortage crisis, which is only expected to worsen. Addressing clinical situations that lead to moral distress may help prevent nursing turnover. Assessing moral distress levels of nurses may give health care organizations an opportunity to intervene early in order to prevent nurse turnover.

There is evidence from the evolving literature and professional discussions that giving voice and recognition to moral distress is a “first step” to nurses speaking up about their ethical concerns for the patient’s welfare (Ulrich, Hamric, & Grady, 2010, p. 21). The American Association of Critical Care Nurses (2008) asserts that all nurses and employers are responsible for implementing programs to address and mitigate the harmful effects of moral distress, thereby creating a healthy work environment. Corley and Minick (2002) emphasize the importance of societal interventions in reducing or preventing moral distress. Input from nursing professionals who have direct knowledge about patient care is needed for development of legislation and resource allocation to improve patient care.

Recommendations for Nurse Administrators and Health Care Organizations

Nurses in this study with relatively lower levels of moral distress were more likely to consider staying in their present position. The number of nurses reporting moral distress may thus help predict turnover rates. Identifying nurses who are experiencing moral distress may give nursing administrators opportunities to intervene in a timely manner to reduce turnover.

The highest intensity of moral distress in this study was produced by staffing levels perceived as unsafe. Nurse administrators can examine nurse-patient ratios and observe their effect on patient outcomes within their organizations. From there, recommendations for safe staffing levels can be determined and supported with data.

The second highest intensity of moral distress found in RNs in this study was with assisting physicians who provide incompetent care. Not taking action because the involved staff member or someone in authority requested them not to, was third in

reported frequency. If nurses in this study had felt free to speak up about clinical situations causing their distress, moral comfort would be more likely to ensue. Gutierrez (2005) proposed facilitating an open communication and a non-punitive work environment so that nurses would not be afraid to voice concerns. Erlen (2001) suggested using trained neutral facilitators in addressing ethical issues so that root causes can be identified and addressed. Collaborative practice models in which physicians, nurses, and other allied health professionals participate in care decisions with patients and their families is recommended as a preventative measure for moral distress. Collaborative practice models have been effective in promoting teamwork, interdisciplinary communication, continuity of care, and quality of care (Hamric, Davis, & Childress, 2006).

The most frequently encountered clinical situations leading to moral distress in this study were about unnecessary testing and futile care. One recommendation to assist with conflicts such as those between family members about end-of-life care is to have interdisciplinary ethics teams that encourage RNs and others who have an ethical concern to initiate ethical consultations (Redman & Fry, 2000).

From the review of literature on moral distress, moral comfort goes hand-in-hand with creating a culture of safety and an ethical work environment. Nurses experience less moral distress and are less likely to leave when they work in a climate they perceive as ethical (Corley et al., 2005; Hamric & Blackhall, 2007; Hart, 2005; Pauly et al., 2009). Health care administrators would be well served to perform routine surveys of moral distress and ethical climate assessments in their organizations. Examining an organization's levels of moral distress and its ethical climate characteristics can help

administrators to understand workplace influences on practice, identify areas for organizational change, and evaluate the effectiveness of actions/interventions initiated by the organization in response to those assessments (Pauly et al., 2009). Penticuff and Walden (2000) recommend providing effective role models for novice nurses and adequate orientation to prevent new staff members from becoming overwhelmed in ethical situations. Erlen (2001) suggests that nurses develop a support system with mentoring and support groups for newer nurses.

Many of the nurses in this study had little or no ethics education beyond their original nursing education programs and some were not sure if they had ever participated in ethics education (59.2%). Based on the review of literature, this is a concern. Hart (2005) found that nurses in their study reported greater intentions to stay in their current positions when they received ethics in-services at the workplace. Schluter, Winch, Holzhauser, and Henderson (2008) revealed that ethics education for nurses may reduce turnover associated with moral distress.

Individual Nurse Recommendations

There are no clear recommendations for individual nurses that arise from the empirical data in this study. From the literature review, Corley (2002) sees nurse activism as a strategy for dealing with moral distress. The Institute of Medicine's (IOM) (2011) landmark report on the future of nursing recommends that nurses become more involved in healthcare policy and reform. The report states that nurses must see policy as something they can shape rather than something that happens to them (IOM, 2011). In order for change to occur, nurses need to acquire leadership roles and actively engage in implementation of healthcare ethics and reform.

Corley's theory stresses the importance of moral courage for nurses in dealing with ethical situations. Nurses need the confidence to dialogue with other parties in clinical situations, deliberate in decision-making, and be accountable for actions. Participation in continuing education activities such as assertiveness training, decision-making, conflict resolution, and communication skill development could be helpful for developing the courage and confidence to vocalize opinions and concerns regarding patient care and organizational constraints. If nurses participate and contribute in policy-making, team planning and patient care conferences, it will help them to know they have played a role in improving health care for patients.

Nurses can be a source of strength and support for colleagues experiencing moral distress. Studies of moral distress revealed that nurses frequently depended on colleagues and co-workers for support in dealing with morally distressing situations (Gutierrez, 2005; Zuzelo, 2007). Willingness to serve as a sounding board and offer empathetic understanding will assist nurses in coping with the negative feelings experienced as a result of moral distress.

Finally, seasoned nurses can serve as mentors and support for novice nurses. Studies of novice nurses have revealed disillusionment, fear, and dissatisfaction with the stress and challenges of nursing. Nurses who felt they were unable to practice according to their values left the profession early in their careers as a result (Maben, Latter, and Clark, 2007; Millette, 1994). Experienced nurses can be a valuable support to novice nurses and enable them to face nursing challenges and achieve professional satisfaction. Extended preceptor programs where the nurse preceptor is compensated for the additional workload burden offer a support strategy for new nurses.

Nurse Educator Recommendations

Research literature suggests that nurse educators who are aware of moral distress can assist students to recognize the phenomenon and discover its sources (Hamric, 2000). Students can be taught to reflect on their own personal values as they are socialized into the values of the profession. When students experience clinical situations in which their values conflict with those of patients, families, physicians, and organizations, the nurse educator can be a facilitative guide. Faculty members who maintain their clinical practices are able to keep current with the ethics of practice environments and present a realistic view of nursing practice.

It is important for nursing faculty to introduce and discuss moral distress. Educators are role models in health care settings. Students benefit from learning strategies for dealing with moral distress, preventing them from becoming overwhelmed when they encounter ethical situations. Simulation and role-playing are teaching strategies that are ideal for helping students build skills for dealing with ethical conflicts.

Summary

This study examined the intensity and frequency of morally distressing clinical situations experienced by RNs in Georgia and its effects on nurse turnover. In this sample of Georgia RNs, those who are electing to stay in their positions report less moral distress than those who either left or are considering leaving their positions.

This study supports prior research suggesting moral distress is a factor in nurse turnover. The study supports maintaining an ethical climate in the workplace as a deterrent to the development of moral distress. Nurse and health care administrators in organizations, individual nurses, and nurse educators all have roles in addressing this

problem and developing strategies to reduce moral distress. Additional research is needed to understand more in depth about the intricacies of moral comfort and moral distress that nurses are experiencing at their workplace.

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Appendix A:

Moral Distress Scale-Revised Nurse Questionnaire (Adult)

Appendix A. *Moral Distress Scale-Revised*
Nurse Questionnaire (Adult)

MDS-R
Nurse Questionnaire (ADULT)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select “0” (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* and *Level of Disturbance*.

	Frequency					Level of Disturbance				
	Never Very frequently					None Great extent				
	0	1	2	3	4	0	1	2	3	4
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.										
2. Witness healthcare providers giving “false hope” to a patient or family.										
3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.										
4. Initiate extensive life-saving actions when I think they only prolong death.										
5. Follow the family’s request not to discuss death with a dying patient who asks about dying.										
6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.										
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										
9. Assist a physician who, in my opinion, is providing incompetent care.										
10. Be required to care for patients I don’t feel qualified to care for.										
11. Witness medical students perform painful procedures on patients solely to increase their skill.										

Appendix A. Moral Distress Scale-Revised
Nurse Questionnaire (Adult)

	Frequency					Level of Disturbance				
	Never Very frequently					None Great extent				
	0	1	2	3	4	0	1	2	3	4
12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
16. Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.										
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										
18. Witness diminished patient care quality due to poor team communication.										
19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
20. Watch patient care suffer because of a lack of provider continuity.										
21. Work with levels of nurse or other care provider staffing that I consider unsafe.										
If there are other situations in which you have felt moral distress, please write them and score them here:										

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I've never considered quitting or left a position _____

Yes, I considered quitting but did not leave _____

Yes, I left a position _____

Are you considering leaving your position now? Yes No

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Appendix B:
Permission to Use Instrument

Appendix B. Permission to Use Instrument

RE: Moral Distress scale

Hamric, Ann (abh4f) [abh4f@virginia.edu]

Sent: Thursday, January 06, 2011 2:36 PM

To: Denise H. Sauls

Cc: Breeden, Catherine (rcb9b) [rcb9b@virginia.edu]

Attachments: MDS-R Description and adu~1.docx (25 KB) ; Nurse Physician Perspectiv~1.pdf (302 KB)

Dear Ms. Sauls,

Thank you for your interest in the Moral Distress Scale – Revised (MDS-R). There are six versions of this scale: nurse, physician and other healthcare professional versions for adult settings (including ICUs and other inpatient units), and parallel versions for healthcare providers in pediatric settings. I have attached information on the current status of testing of these instruments, and the adult nurse version. NOTE that pilot testing for reliability and discriminant validity has not yet been completed. I currently am gathering data to test the scale and should have results by the end of January, 2011.

The attachment also lists an article I published using an earlier short form of the MDS. This was developed for end-of-life care in ICU settings, with many items specific to that area. This newer MDS-R is designed to be more broadly applicable, but as you can see, we have not completed reliability and validity testing yet. There are many studies of moral distress among nurses using Corley's original 38-item instrument, as you probably already know by now. I've attached a copy of the Hamric/Blackhall study for your review, if interested.

If you wish to use the MDS-R, please see the conditions for use in the attached document. Let me know if you are interested in other versions of the instrument besides the one attached. If you agree to adhere to the conditions for use, I am happy to give you permission to use the scales. If you decide to change items for particular specialty purposes or for different settings or outside the USA, Dr. Corley and I request that you keep us informed of the changes you make and the results you obtain. Note that you will need to agree to share your data in an SPSS file with us. This is for the purpose of improving the utility of the MDS-R.

Best wishes for success with your research!

Ann Hamric

Ann B. Hamric, PhD, RN, FAAN

Professor, School of Nursing

University of Virginia

P.O. Box 800782

McLeod Hall

Charlottesville, VA 22908-0782

Phone: 434.924.0112

Fax: 434.982.1809

Email: abh4f@virginia.edu

From: Denise H. Sauls [mailto:dhsauls@valdosta.edu]

Sent: Monday, December 20, 2010 3:48 PM

Appendix C:

Permission to Amend Instrument

Appendix C. Permission to Amend Instrument

RE: MDS-R

Page 1 of 1

RE: MDS-R

Hamric, Ann (abh4f) [abh4f@virginia.edu]

Sent: Tuesday, March 22, 2011 12:10 PM

To: Denise H. Sauls

Attachments: MDS-R Description and adu~1.docx (25 KB)

Dear Ms. Sauls,

My apology for the delay in responding to your request. I've attached a newer description that includes the results of our initial reliability and validity testing on the MDS-R. I think these data will be useful to you in your thesis.

To me, the question implies "due to moral distress" because it is a follow-up to the question above it. But if you feel more comfortable adding this clause to the last question, by all means do so.

Best wishes,

Ann

From: Denise H. Sauls [mailto:dhsauls@valdosta.edu]

Sent: Monday, March 21, 2011 10:32 AM

To: Hamric, Ann (abh4f)

Subject: MDS-R

Dear Dr. Hamric,

I last wrote to you in January concerning permission to use the MDS-R Nurse Questionnaire (ADULT) in my research on moral distress among nurses for my Master's thesis. I understand the terms for use of the instrument and will be happy to comply. I have finished the first three chapters of my thesis and am awaiting committee approval of my study.

I am preparing to meet with my thesis committee this week and approach my university's IRB for approval of my study. I have one question to ask you. The question concerns the final question at the end of the instrument, "Are you considering leaving your position now?" Do you have any objection to my inserting "due to moral distress" into the question? I want to make sure respondents do not indicate leaving their current positions for any reason other than moral distress.

Thanks,

Denise Sauls

Valdosta State University

<https://sn2prd0202.outlook.com/owa/?ae=Item&t=IPM.Note&id=RgAAAAChGt4h4R5cT7...> 4/3/2011

Appendix D:
Institutional Review Board Approval



*Institutional Review Board (IRB)
for the Protection of Human Research Participants*

PROTOCOL EXEMPTION REPORT

PROTOCOL NUMBER: IRB-02678-2011

INVESTIGATOR: Denise Sauls

PROJECT TITLE: Moral Distress Experienced by Registered Nurses in Georgia and its Impact on Nurse Turnover

DETERMINATION:

- ✓ This research protocol is exempt from Institutional Review Board oversight under Exemption Category(ies) 2. You may begin your study immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

 - ☐ Exemption of this research protocol from Institutional Review Board oversight is pending. You may **not** begin your research until you have addressed the following concerns/questions and the IRB has formally notified you of exemption. You may send your responses to irb@valdosta.edu.
-

ADDITIONAL COMMENTS/SUGGESTIONS:

Although not a requirement for exemption, the following suggestions are offered by the IRB Administrator to enhance the protection of participants and/or strengthen the research proposal. If you make any of these suggested changes to your protocol, please submit revisions so that IRB has a complete protocol on file.

Barbara H. Gray _____ Date: 6/23/11
Barbara H. Gray, IRB Administrator

*Thank you for submitting an IRB application.
Please direct questions to irb@valdosta.edu or 229-259-5045.*

cc: Dr. Anita Hufft (Dean – CON)
Dr. Nancy Redfern-Vance

Appendix E:
Demographic Data Collection Form

Appendix E. Demographic Data Collection Form

1. Are you a licensed registered nurse?
 - Yes (If you are an RN, please continue with the survey)
 - No (If the answer is no, do not continue)

2. What is your age? _____

3. What is your gender?
 - Male
 - Female

4. What is your ethnicity?
 - African American
 - Asian
 - Caucasian
 - Hispanic
 - Native American
 - Other
 - Do not wish to answer

5. What is your highest level of education?
 - ADN
 - Diploma
 - BSN
 - MSN
 - APRN
 - Master's other
 - Doctorate Nursing
 - Doctorate Other

6. What is your current primary nursing role?
 - Staff nurse

- Nurse administrator
- Public health nurse
- Hospice nurse
- Nurse educator
- Other _____

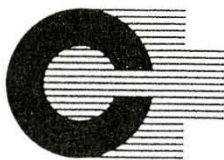
7. What is your current practice setting? _____

8. How many years have you practiced as a nurse? _____

9. How many hours of formal ethics education have you participated in since your basic nursing education program? _____

Appendix F:
Organization Participation Agreements

Appendix F. Organization Participation Agreement



CRISP REGIONAL HOSPITAL

May 9, 2011

Valdosta State University
Members of the IRB Committee
1500 North Patterson Street
Valdosta, GA 31698-0280

Dear Members:

Crisp Regional Hospital is pleased to approve the request of Denise Sauls to approach nursing staff for inclusion in her survey on a voluntary basis.

For additional information, please contact my office by dialing (229) 276-3105.

Sincerely,

A handwritten signature in black ink that reads "Marsha Mulderig RN". The signature is written in a cursive style.

Marsha Mulderig, RN, MSN, MBA
Chief Nursing Officer

/ga

Appendix F. Organization Participation Agreement



Lanier Health Services, Inc.

A South Georgia Health System Affiliate

May 2, 2011

Valdosta State University
Members of the IRB Committee
1500 North Patterson Street
Valdosta, GA 31698-0280

Dear Members:

Louis Smith Memorial Hospital and Lakeland Villa Convalescent Center are pleased to approve the request of Denise Sauls to approach nursing staff for inclusion in her survey on a voluntary basis.

For additional information, please contact my office by dialing (229) 482-8402.

Sincerely,

Neil W. Ginty
Administrator

Appendix F. Organization Participation Agreement

From: Sandra Donovan <sandy.donovan@tiftregional.com>
To: Denise Sauls <dhs1117@yahoo.com>
Sent: Wed, May 25, 2011 1:12:10 PM
Subject: Research

Denise,

I wanted to let you know that last week our AVP for Inpatient Services gave approval for us to send out your request for participation. She asked each of her nurse managers to send the request to their RNs. We did this through email. I apologize for not touching base last week when this took place. My schedule has had me out of the office a great deal and running from one project to another, so my office and email time isn't getting the attention I like to be able to communicate.

Anyway, I wanted to let you know and also to ask if you would be willing to share your results with us when you complete your work. Our AVP requested this as she sees the relevance of the work you are doing and would like to know the outcome. If you would email me when you have your results, I will be glad to forward to her.

Thanks for giving us the opportunity to participate. ☺

*Have a great day,
Sandy*

Sandra L. Donovan, RN , MSN
Net Learning & Student Liaison Coordinator
Education Department
Tift Regional Medical Center
901 East 18th Street
P O Box 747
Tifton, GA 31794
(229) 353-7793
FAX (229) 353-6420

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Appendix G:
Recruitment Postcard

CALLING ALL REGISTERED NURSES



If you are a registered nurse working in Georgia, I would like to invite you to participate in a survey as a part of a study I am conducting for my Master's thesis entitled, "Moral Distress Experienced by Registered Nurses in Georgia and Its Impact on Nurse Turnover". The purpose of this study is to explore the intensity and frequency of moral distress among registered nurses (RNs) working in health care in Georgia to see if moral distress is a reason for nurses to leave or consider leaving their nursing positions. Nurses are vulnerable to moral distress because of the inherent moral nature of nursing and because of their position as patient advocate. Moral distress is defined as the anguish suffered in response to a situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, makes a moral judgment about the correct action, and yet is unable to take that action. Moral distress can lead to job dissatisfaction and turnover for nurses. I hope that this study will provide nurses and health care administrators with an understanding of moral distress so they can address strategies to prevent or reduce its occurrence and its negative impacts.

All information is confidential and gathered via an internet survey and should take no longer than 10-15 minutes to complete. If you are willing to participate in the survey, please go to <https://www.surveymonkey.com/s/LPJMF7Y>. Please complete the survey as soon as possible. Thank you for your willingness to participate.

Denise Sauls, BSN, RN. Contact me at dhsauls@valdosta.edu or at 229-244-0777 for any questions.

Appendix H:
Recruitment Flyer

CALLING ALL REGISTERED NURSES



If you are a registered nurse working in Georgia, I would like to invite you to participate in a survey as a part of a study I am conducting for my Master’s thesis entitled, “Moral Distress Experienced by Registered Nurses in Georgia and Its Impact on Nurse Turnover”. The purpose of this study is to explore the intensity and frequency of moral distress among registered nurses (RNs) working in health care in Georgia to see if moral distress is a reason for nurses to leave or consider leaving their nursing positions. Nurses are vulnerable to moral distress because of the inherent moral nature of nursing and because of their position as patient advocate. Moral distress is defined as the pain or anguish suffered in response to a situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, makes a moral judgment about the correct action, and yet is unable to take that action.

Moral distress can lead to job dissatisfaction and turnover for nurses. I hope that this study will provide nurses and health care administrators with an understanding of moral distress so they can address strategies to prevent or reduce its occurrence and its negative impacts.

All information is confidential and gathered via an internet survey and should take no longer than 10-15 minutes to complete. If you are willing to participate in the survey, please follow the link: <https://www.surveymonkey.com/s/LPJMF7Y>. Please complete the survey as soon as possible. Thank you for your willingness to participate.

Denise Sauls, BSN, RN. Contact me at dhsauls@valdosta.edu or at 229-244-0777 for any questions.

Denise Sauls, 229-834-6582 dhsauls@valdosta.edu Surveymonkey https://www.surveymonkey.com/s/LPJMF7Y	Denise Sauls, 229-834-6582 dhsauls@valdosta.edu Surveymonkey https://www.surveymonkey.com/s/LPJMF7Y	Denise Sauls, 229-834-6582 dhsauls@valdosta.edu Surveymonkey https://www.surveymonkey.com/s/LPJMF7Y	Denise Sauls, 229-834-6582 dhsauls@valdosta.edu Surveymonkey https://www.surveymonkey.com/s/LPJMF7Y
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Appendix I:
E-Mail Invitational Letter

Appendix I. E-Mail Invitational Letter

Title of Project: Moral Distress Experienced by Registered Nurses in Georgia and Its Impact on Nurse Turnover

My name is Denise Sauls and I am a Master's Candidate at Valdosta State University, College of Nursing. If you are working as an RN in Georgia, I invite you participate in my thesis study. The purpose of this study is to explore the intensity and frequency of moral distress among registered nurses (RNs) working in health care in Georgia to see if moral distress is a reason for nurses to leave or consider leaving their nursing positions. Moral distress is defined as the anguish suffered in response to a situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, makes a moral judgment about the correct action, and yet is unable to take that action. Nurses are vulnerable to moral distress because of the inherent moral nature of nursing and because of their position as patient advocate.

Your participation will involve answering a brief online questionnaire about situations you may have encountered working as a nurse causing you to experience moral distress. You will also be asked for demographic information about your age, gender, ethnicity, educational level, years of experience, and if you have participated in ethics education previously. Your name or the institution where you work will NOT be asked and therefore, will not appear on any reports that results from this project. The online questionnaire will be accessed through SurveyMonkey.com, an online questionnaire tool. SurveyMonkey employs multiple layers of protection to ensure that accounts remain private.

You will enter the survey site from any computer, at a time convenient for you, using a web address. After you enter the web address, you will be able to access and answer the questionnaire. Neither I, nor the health care facility in which you are employed, can track your participation. The questionnaire takes approximately 10-15 minutes to complete. It is up to you whether you wish to participate in the study and you have the right to refuse to participate at any time. Your participation is anonymous and confidential. All provided information, de-identified by SurveyMonkey, will be maintained on a password-protected computer jump drive. There are no anticipated risks from participation in this study.

At the conclusion of the study, and after the data are analyzed, I will provide a copy of the published study to Odum Library at Valdosta State University. By completing the on-line questionnaire, you are giving your permission for me to use your information for research purposes. By completing the on-line questionnaire, you are also giving your permission for me to send research results to Dr. Ann Hamric, developer of the survey instrument, who is in the process of validating the instrument. Your identity will remain confidential.

If you have any questions, feel free to contact me. I can be reached at (email) dhsauls@valdosta.edu or (phone) 229-244-0777. This study has been exempted from Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-259-5045 or irb@valdosta.edu.

Thank you for your consideration and I hope you will consider participating in this study.

Appendix J:

Mean Item Scores for Frequency by Rank

Appendix J: Mean Item Scores for Frequency by Rank

Clinical Situations	Frequency
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	2.33
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	2.10
Initiate extensive life-saving actions when I think they only prolong death.	1.99
Witness diminished patient care quality due to poor team communication.	1.71
Watch patient care suffer because of a lack of provider continuity.	1.68
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	1.67
Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	1.53
Work with levels of nurse or other care provider staffing that I consider unsafe.	1.45
Witness healthcare providers giving "false hope" to a patient or family.	1.44
Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	1.41
Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.	1.30
Follow the family's request not to discuss death with a dying patient who asks about dying.	1.06
Assist a physician who, in my opinion, is providing incompetent care.	1.18
Be required to care for patients I don't feel qualified to care for.	.94
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	.93
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	.91
Ignore situations in which patients have not been given adequate information to insure informed consent.	.70
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	.69
Witness medical students perform painful procedures on patients solely to increase their skill.	.53
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	.42
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	.38

Appendix K:

Mean Item Scores for Level of Disturbance (Intensity) by Rank

Appendix K: Mean Item Scores for Level of Disturbance (Intensity) by Rank

Clinical Situations	Level of Disturbance
Work with levels of nurse or other care provider staffing that I consider unsafe.	3.40
Assist a physician who, in my opinion, is providing incompetent care.	3.37
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	3.31
Be required to care for patients I don't feel qualified to care for.	3.27
Work with nurses or other healthcare providers who are not As competent as the patient care requires.	3.22
Witness diminished patient care quality due to poor team communication.	3.19
Watch patient care suffer because of a lack of provider continuity.	3.17
Witness medical students perform painful procedures on patients solely to increase their skill.	3.16
Ignore situations in which patients have not been given adequate information to insure informed consent.	3.11
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	3.10
Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	3.09
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	3.03
Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.	2.89
Follow the family's request not to discuss death with a dying patient who asks about dying.	2.88
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	2.82
Witness healthcare providers giving "false hope" to a patient or family.	2.74
Initiate extensive life-saving actions when I think they only prolong death.	2.70
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	2.65
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.	2.64
Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	2.63
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	2.57