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NURSE MANAGERS' MORAL DISTRESS IN THE CONTEXT OF THE HOSPITAL ETHICAL CLIMATE

by

Rebecca Blanche Porter

An Abstract

Of a thesis submitted in partial fulfillment of the requirements
for the Doctor of Philosophy degree in Nursing
in the Graduate College of The University of Iowa

December 2010

Thesis Supervisor: Professor Janet K. Williams

ABSTRACT

Moral distress is a negative emotional and somatic response to external constraints on moral action. The constraints are typically identified as a component of the work environment, called the ethical climate. Moral distress is identified as a primary reason for job attrition by up to one-quarter of registered nurses who leave their jobs. One strategy suggested to staff nurses who experience moral distress is to consult their Nurse Manager (NM). However, the moral distress of NMs who are employed in acute care hospitals is poorly understood. The purpose of this qualitative study was to examine NMs' perceptions of the external constraints on moral agency, specifically the hospital ethical climate, which leads to their experience of moral distress and to analyze how attributes of the ethical climate facilitated or impeded their resolution of moral distress.

Semi-structured, audio-recorded telephone interviews were conducted with 17 NMs from across the United States. An interpretive description design using an iterative process between data collection and data analysis was used. Data were analyzed through descriptive coding and thematic analysis.

The participants in this study were 15 women and 2 men with a mean age of 46.4 years. The mean length of time in their current positions was slightly less than 5 years. Of the 17 hospitals represented, 6 were affiliated with a university and 4 had a religious affiliation. Fifteen of 17 NMs described situations in which the implicit and explicit values of the hospital were incongruent with their personal moral values and professional ethics. Common themes describing factors contributing to moral distress were administrative policies, negative communication patterns and relationships with physicians, issues related to staff nurses, issues related to patients and families, and multiple competing job obligations. Respondents described strategies to navigate through their moral distress. The strategies included taking a positive perspective, seeking the advice of NM colleagues, reliance on a positive relationship with a supervisor, and

talking it through with family members. For 5 of the 15 NMs who experienced moral distress, their final strategy included plans to resign from their positions.

Issues within the ethical climate of the hospital that were perceived to contribute to the development of moral distress among this cohort of NMs differed from those reported for staff nurses. Further examination of strategies used by NMs to improve the ethical climate may yield insights into effective ways to address moral distress for this population.

Abstract Approved: ___________________________________
Thesis Supervisor

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Title and Department

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Date

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Graduate College
The University of Iowa
Iowa City, Iowa

CERTIFICATE OF APPROVAL

PH.D. THESIS

This is to certify that the Ph.D. thesis of

Rebecca Blanche Porter

has been approved by the Examining Committee for the thesis requirement for the Doctor of Philosophy degree in Nursing at the December 2010 graduation.

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Sue Moorhead

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Elizabeth A. Swanson

To my parents
Iris W. Porter (1923-2005) and J. Charles Porter (1922-2009)

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CHAPTER I

INTRODUCTION

Problem Statement

Moral Distress

Moral distress has been identified as a significant practice issue for registered nurses (RNs) in the United States. The importance of moral distress to nursing practice has been widely recognized and discussed in professional reports by the American Nurses' Association (Nathaniel, 2002), the American Association of Critical Care Nurses (2006), NANDA International (Kopala & Burkhart, 2005), and lay journal media (Appendix B). Although not naming it as such, the Institutes of Medicine and the Agency for Healthcare Research and Quality recently described some sources of moral distress in reports regarding patient safety and quality of care (Hughes, 2008; Institute of Medicine [U.S.] Committee on Quality of Health Care in America, 2001; Page, 2004). These reports described commonly known and empirically derived indicators of patient safety and quality of care, such as the shortage of nurses, nurse burnout, evolving leadership strategies, the dilemmas of meeting competing obligations, and issues related to organizational climate, such as the ethical climate of the organization. Although well-recognized in nursing administration and health care management research literature, these topics also appear in nursing ethics and healthcare ethics empirical literature; however, the difference between the two bodies of literature rests in contextual frameworks. That is, in the nursing ethics literature, the contextual framework is moral distress and ethical climate. In contrast, the nursing administration literature considers these topics not as ethical issues but within frameworks related to job satisfaction or job attrition. The concept of moral distress has only recently transitioned into the nursing administration and health care management literature. However, the collection of these reports and a growing body of empirical evidence substantively describes a connection between moral distress and indicators of quality and safety of clinical patient care in

addition to RN well-being in the context of the current ethical climate within hospital organizations.

Among the indicators of quality and safety of clinical patient care, one of the predominant issues has been insufficient numbers of RNs. A substantive research body has linked the consequences of RN workforce shortages with quality and safety of clinical patient care (Aiken & Fagin, 1997; Aiken, Sochalski, & Anderson, 1996; Buerhaus, Staiger, & Auerbach, 2000b; Clark, Leddy, Drain, & Kaldenberg, 2007; Joint Commission on Accreditation of Health Care Organizations, 2002; Sochalski, Aiken, & Fagin, 1997). The current severe economic recession has caused an increased number of RNs to return to work, thus giving the appearance of an end to this cycle of the RN shortage (Buerhaus, Auerbach, & Staiger, 2009). However, scholars predict that when this current recession ends, there will be a more serious RN shortage than previously estimated because even larger numbers of RNs will retire, leaving insufficient numbers in the replacement workforce (Buerhaus et al., 2009).

Of key significance is that despite economic downturns, RNs continue to leave nursing positions or leave the profession entirely. In some studies, moral distress was linked with a 15% to 25% attrition rate in the RN workforce (Corley, 1995, 1998a; Corley, Minick, Elswick, & Jacobs, 2005; Hamric, 2001). Recent research by Austin (Austin, 2007; Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005), Corley (Corley et al., 2005), Fogel (Fogel, 2007) and Ulrich (C. Ulrich et al., 2007) added to earlier calls (Hamric, 2000; Powell, 1997; Wilkinson, 1987-1988, 1997) for further studies to consider nurses' moral distress in the context of the workplace environment, particularly the ethical climate.

Moral conflict is an inevitable part of the work of nursing. Although the Nursing Code of Ethics provides the legal and ethical structure for the work of nursing, moral distress is a relatively common occurrence among nurses. It has been extensively described among various groups of clinical staff RNs, particularly in critical and acute

care settings and much less among palliative care, long term, or community care nurses. Studies have included neonatal/perinatal intensive care nurses (Catlin, 2006; Hefferman & Heilig, 1999; Janvier, Nadeau, Deschenes, Couture, & Barrington, 2007; Kain, 2007; D. A. Raines, 1994; Tiedje, 2000; Wilkinson, 1989), pediatric nurses (Davies et al., 1996; Linnard-Palmer & Kools, 2005; O'Haire & Blackford, 2005; Perkin, Freier, & Orr, 1997), pediatric intensive care nurses (Montagnino & Ethier, 2007; Perkin et al., 1997; Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997), pediatric oncology nurses (Davies et al., 1996), medical-surgical nurses (Ferrell, 2006; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Torjuul & Sorlie, 2006), critical care nurses (Corley, 1995, 1998a; Corley, Elswick, Gorman, & Clor, 2001; Cronqvist, 2001; Elpern, Covert, & Kleinpell, 2005; Fogel, 2007; Gutierrez, 2005; Hamric & Blackhall, 2007; Henneman, Blank, Gawlinski, & Haenneman, 2006; McClendon & Buckner, 2007; McLendon & Buckner, 2007; Melia, 2001; Meltzer & Huckabay, 2004; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Rodney, 1988; Rushton, 2006; Stechmiller & Yarandi, 1993), geriatric care nurses, especially in long-term care/dementia care (Bolmsjo, Edberg, & Sandman, 2006), palliative care nurses (Georges & Grypdonck, 2002), and military/combat nurses (Fry, Harvey, Hurley, & Foley, 2002; Scannell-Desch, 2000).

One of the roles of Nurse Manager (NM) is that of a professional resource for clinical staff RNs. When clinical staff RNs experience professional conflict, particularly moral conflict, they typically turn to the unit NM for help in conflict resolution. However, the literature is largely silent on the topic of moral distress management experienced by NMs, or even the occurrence of moral distress within this component of the nursing workforce. Like staff RNs, the NM is accountable to multiple stakeholders, such as patients, the hospital organization, third-party payers, and professional colleagues. And, as with all RNs, NMs are guided not only by their own personal morals and values but also by the American Nurses Association Code of Ethics for Nurses (American Nurses Association, 2001). Yet, little research exists describing NMs'

experience of moral distress. Clearer understanding of the perceptions of moral distress by NMs is the first step in this program of scholarly inquiry to better understand the complex relationships among moral distress, components of nurse well-being, professional integrity, and the ethical climate of the employing organization.

Ethical Climate

Attention has been paid in the nursing and health care administration literature to influences within the organizational milieu that affect employee's attitudes, behaviors, and ethical beliefs (Corley et al., 2005; Hart, 2005; L. L. Olson, 1995; Spencer, Mills, Rorty, & Werhane, 2000). It is this organizational milieu in which moral distress develops. The concept of ethical climate, as a notion within the concept of organizational climate, is an established topic of research in sociology and business literature (Cullen, Victor, & Bronson, 1993; MacDaniel, 1997; Schminke, Arnaud, & Kuenzi, 2007; Schneider, 1975; Schwepker, 2001; Victor & Cullen, 1988; Wimbush & Shepard, 1994), and more recently in the empirical health care organizational and nursing literature (R. W. Cooper, Frank, Gouty, & Hansen, 2002; R. W. Cooper, Frank, Gouty, & Hansen, 2003; Corley, 1998a; Corley et al., 2005; Fogel, 2007; Gershon, Stone, Bakken, & Larson, 2004; Hart, 2005; Joseph & Deshpande, 1997; Laschinger, Almost, Purdy, & Kim, 2004; Laschinger, Purdy, Cho, & Almost, 2006; MacDaniel, 1997; McDaniel, 1998; McDaniel, Veledar, LeConte, Peltier, & Maciuba, 2006; Olson, 1998; L. L. Olson, 1995; Rathert & Fleming, 2008; Shirey, 2005; Sochalski et al., 1997; Torjuul & Sorlie, 2006; B. T. Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005; C. Ulrich et al., 2007; C. Ulrich, Soeken, & Miller, 2003; Weiss, Malone, Merighi, & Benner, 2002; Wlody, 2007). Ethical climate and moral distress, specifically, have been linked in a growing body of nursing research related to RNs' job satisfaction and attrition (Corley et al., 2005; Gaudine & Beaton, 2002; Hart, 2005; McDaniel, 1997; M. L. Raines, 2000; Rice et al., 2008; Shirey, 2006; Shirey, Ebright, & McDaniel, 2008). Of this body of research, only three studies (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008) were

specifically concerned with NMs' perceptions of the organization's ethical climate and moral distress. Furthermore, the concepts of ethical climate and moral distress were not research topics, but emerged in the (qualitative) data analysis. So, despite the rising recognition of the importance of the ethical climate for nursing practice, there is little research describing NMs' perspectives on this relevant topic and even less research that specifically describes their experiences of moral distress in the context of the ethical climate of the organization.

Focus of the Dissertation

A majority of the knowledge regarding ethical climate and moral distress was developed in studies of critical care and acute care RNs, and little is known about the phenomenon in this cohort of NMs. Therefore, the focus of this dissertation was to illuminate the meanings that acute and critical care NMs attribute to the ethical climate of their employing hospitals during incidents they describe as morally distressing. This qualitative interpretive description study examined both the context and the experience of NMs' experiences of moral distress in acute care hospitals in the United States. Telephone interviews were conducted with self-identified NMs who were part of a critical care and acute care network of RNs. The details of the study design are presented in Chapter III. The study results contribute to the growing body of empirical literature regarding moral distress among RNs, in general, and to the small body of knowledge about NMs' experiences, in particular.

Following the Problem Statement in Chapter I, the section titled "Background and Significance" presents an overview of the concept of moral distress and the role of the NM, particularly in the context of moral distress and the ethical climate of the work place. The dissertation Purpose and Specific Aims will be presented, and the chapter concludes with a section of Definitions of Terms, and then a Summary section that will lead to Chapter II, the Literature Review.

Background and Significance

Moral Distress Overview

Situated within the ethical domain of nursing practice, moral distress conceptually captures the essence of the human response to a situation in which one's pursuit of "the good" is blocked by personal (internal) or institutional (external) constraints. Generally, moral distress has been defined as a psychological and somatic *process* that evolves over time and is thought to be the discomfort that results when a nurse knows the morally right course of action in a particular situation but fails to pursue that action because of internal or external constraints (Jameton, 1984; Wilkinson, 1987-1988, 1989). Other slightly different conceptual understandings of moral distress exist in the prevailing moral distress literature (Austin, Lemermeyer, et al., 2005; Corley, 1995, 2002; Corley et al., 2001; Fry, et al., 2002; Nathaniel, 2006); however, the foundational definitions by Jameton (1984, 1993) and Wilkinson (1987-1988, 1997) are frequently used and guided the framework for this study.

Development of the Concept in Extant Nursing Literature

Although moral distress is a part of the human condition, nurses' experience of being morally distressed has been recognized in nursing empirical literature for at least six decades (Ashley, 1976; Holsclaw, 1965; E. M. Jones, 1962; Maryo & Lasky, 1959; Miller, 1940; Nahm, 1940; Travelbee, 1964). However, naming the concept did not occur until later in the 20th century. The term *moral distress* is commonly attributed to the moral philosopher Jameton (1984), who observed in an ethnographic study of hospital nurses that despite their awareness of a particular dilemma, some hospital staff RNs became visibly distressed and felt powerless when their efforts to advocate for the patient were thwarted. Actions were most frequently thwarted by constraints external to the nurses' own moral agency. For the purpose of this paper, moral agency is understood to be the integration of one's personal and professional moral responsibilities.

Most of the studies of moral distress among clinical staff RNs focused on the external constraints of practice. Factors included hospital bureaucracy, hierarchical hospital social structure, scarce resources, poor intra-disciplinary communication, an ethical climate that did not support the nurse-patient relationship (particularly among terminally ill patients), medically futile care, and the culture of teaching hospitals (Davies et al., 1996; Erlen & Frost, 1991; Ferrell, 2006; Fry et al., 2002; Gutierrez, 2005; Janvier et al., 2007; McLendon & Buckner, 2007; Meltzer & Huckabay, 2004; Mobley et al., 2007; Oberle & Hughes, 2001; Rice et al., 2008; Rodney, 1988; Sundin-Huard & Fahy, 1999).

Consequences of Moral Distress

With respect to the process, moral distress affects the well-being or "wholeness" of RNs, has implications for patient care, and presents cost containment issues for the hospital (Wilkinson, 1987-1988, 1997), in addition to the personal and professional costs of nurses who leave a position because of moral distress. The experience of moral distress depends, in large part, on the individual's perception of the ethical climate of the work environment. Three considerations related to the documented consequences of moral distress are discussed in the following section. The three considerations are the consequences to nurses' well-being, effect of nurses' moral distress on patient care, and the relationship between moral distress and professional and positional attrition.

Effect of Moral Distress on Nurses' Well-Being

Documented consequences of unresolved moral distress are linked to the well-being of individual nurses and include symptoms of physical and emotional stress leading to the well-known nurse burnout syndrome (Corley, 1995, 2002; Corley et al., 2001; Cronqvist, Lutzen, & Nystrom, 2006; Davies et al., 1996; Fry et al., 2002; M. L. Raines, 2000; Severinsson, 2003; Sundin-Huard & Fahy, 1999), job dissatisfaction (Begat, Ellefsen, & Severinsson, 2005; Corley, 1995; Wilkinson, 1987-1988), and professional attrition (Corley et al., 2001; Corley & Minick, 2002; Fry et al., 2002; Hart, 2005;

Wilkinson, 1987-1988). Somatic consequences of moral distress are described as palpitations, headaches, sleep disturbances (i.e., insomnia, hypersomnia, nightmares), and alterations in bodily functions (Fry et al., 2002; Gutierrez, 2005; Wilkinson, 1987-1988). Psychological consequences include a sense of disequilibrium, decreased self-confidence, guilt, remorse, anxiety, frustration, lack of energy, emotional exhaustion, feeling unproductive, withdrawal from family and friends, and deep sadness (Davies et al., 1996; Fenton, 1988; McLendon & Buckner, 2007; Meltzer & Huckabay, 2004; Mobley et al., 2007; Rice et al., 2008).

Impact of Moral Distress on Patient Care

Nurses report that moral distress impacts their professional life because unrelenting exhaustion leads to burnout, distancing from patients and families, inappropriate joking, feeling less effective, and a hesitancy to "connect" with patients (Davies et al., 1996; Fenton, 1988; McLendon & Buckner, 2007; Meltzer & Huckabay, 2004; Mobley et al., 2007; Rice et al., 2008). In a manner similar to nurses' behaviors in the burnout syndrome, moral distress has also been linked to maladaptive behaviors, such as avoidance of patients' calls for help (Corley, 1995; Shortell et al., 1994) and avoidance of dying patients (Kelly, 1998). Thus, in addition to the suffering in nurses caused by moral distress, patients' suffering can be worsened because the nurse is deliberately not present. Moreover, the consequences directly impact costs associated with employee health, nurse retention, job turnover, and thus patient safety and quality of care.

Nursing Shortage

The specific issue of moral distress as a causative factor for staff RNs intention to leave a job was investigated among critical care RNs in two tertiary care hospitals (Fogel, 2007). This study revealed a significant relationship between the level of moral distress and the intention to leave a position, and a negative perception of the ethical climate correlated with a higher intention to leave a position (Fogel, 2007). In other studies, attributes consistent with moral distress have been implicated as a contributing factor in

the current nursing shortage, especially in critical care and the operating room (Buerhaus et al., 2000b; Gillespie, Wallis, & Chaboyer, 2008; Page, 2004). In studies of the consequences of moral distress, data analysis revealed that between 15% and 25% of clinical staff RNs who have left a position did so because of moral distress (Elpern et al., 2005; Fogel, 2007; Hart, 2005; Wilkinson, 1987-1988, 1997). Given the direct and extrapolated conclusions of these studies, evidence exists that moral distress is an important contributing factor to working conditions.

Research on nursing professional attrition has consistently articulated four contributing and interrelated workforce factors: (a) dissatisfaction with the work environment (Auerbach, Buerhaus, & Staiger, 2007; Blegen, 1993; Buerhaus, Donelan, Ulrich, DesRoches, & Dittus, 2007; Goodin, 2003; Joint Commission on Accreditation of Health Care Organizations, 2002), including ethical climate (Hart, 2005); (b) an aging workforce (Aiken et al., 1996; Auerbach et al., 2007; Buerhaus, Staiger, & Auerbach, 2000a; Health Resources and Services Administration, 2002; Heinrich, 2001; Lin, Lee, Juraschek, & Jones, 2006); (c) a relatively weak public image and understanding of the work that nurses do (Kalisch, Begeny, & Neumann, 2007); and (d) fewer people choosing nursing as a first career (Buerhaus et al., 2000b; Heinrich, 2001). The relevance of considering these interrelating workforce factors is that moral distress has not been included as a distinct contributing factor in the nursing administration work environment literature. The experience of moral distress is, by definition, a reflection of the work environment, including intra-professional relationships, but currently is not considered as a distinct factor. Thus, its importance as a contributing factor to the nursing shortage may be underestimated. Previous research suggests that the ethical climate, as a part of the work environment, is an important component of the moral distress experience (Gaudine & Beaton, 2002; McDaniel, 1997; M. L. Raines, 2000; Shirey, 2005; C. Ulrich, et al., 2007) and job attrition (Corley et al., 2005; Fogel, 2007; Hamric & Blackhall, 2007).

In summary, moral distress can be a significant work-place issue with direct consequences on RNs' health and well-being and quality of patient care, and can directly influence a nurse's decision to leave a position. Although it remains relatively invisible within the job turnover literature, the attributes of moral distress can be extrapolated from that body of literature and provide evidence to support the notion that moral distress plays an influential role in job satisfaction and nursing attrition.

Interventional Strategies to Control Moral Distress

Nurse Managers are expected to provide resources to address the moral distress of staff RNs, such as opportunities to discuss ethical dilemmas, interdisciplinary ethical rounds, access to clinical ethics committees, and participation in policy development (American Association of Critical-Care Nurses, 2005a; Corley, 1998b; Fenton, 1988; Gutierrez, 2005; Meltzer & Huckabay, 2004; Zuzelo, 2007).

A particular set of published guidelines to assist clinical staff nurses with the resolution of moral distress, "The 4A's to Rise Above Moral Distress" represents one of the strategic initiatives of the AACN in addressing issues that affect the workplace environment (American Association of Critical-Care Nurses, 2005; American Association of Critical-Care Nurses, 2006). One of the recommended actions is to consult the NM or an advanced practice nurse on the unit. However, since little evidence has documented NMs' knowledge of moral distress, approaches to responding to these contacts, or their own experience of moral distress, this recommendation may not yield the intended results for staff nurses.

Moral Distress and Acute/Critical Care Nurse Managers

Role of the Nurse Manager in Acute or Critical Care Hospital Units

There are 2.5 million RNs in the United States (American Hospital Association, 2006; Health Resources and Services Administration, 2002), of whom more than half are employed in acute care hospitals (American Hospital Association, 2006). Among this

group of acute care RNs, almost 10% are employed in Nurse Managerial positions (Health Resources and Services Administration, 2002). Nurse Managers in acute care hospitals are strategically placed within the organizational structure of the hospital as an essential link between clinical bedside RNs and hospital executive administration. In this position, they are responsible for the daily operations at the unit level of the hospital to ensure safe, efficient, and high-quality patient care (Cooke, 2002; Parsons & Stonestreet, 2003; Skytt, Ljunggren, & Carlsson, 2007). They are further charged with the responsibilities of fostering a positive work environment and ensuring nurse retention (Acorn, Ratner, & Crawford, 1997; Boyle, Bott, Hansen, Woods, & Taunton, 1999; Boyle, Miller, Gajewski, Hart, & Dunton, 2006; Patrick & Laschinger, 2006). Not only do NMs carry these responsibilities for multiple units, but they are additionally challenged to implement rapidly changing models of health care delivery to meet dynamic strategic goals of the hospital (Anthony et al., 2005; Kimball, Joynt, Cherner, & O'Neil, 2007; McGillis Hall & Donner, 1997; Page, 2004; Shirey, 2006). Thus, NMs require the support of hospital and nursing administration in addition to the human and material resources to fulfill their multiple and often competing professional obligations (Parsons & Stonestreet, 2003; Patrick & Laschinger, 2006; Shirey, 2006; Skytt et al., 2007) and at the same time, are obliged to ensure that staff RNs have the needed resources and climate in which to fulfill their patient care obligations. Thus, NMs indeed “straddle” two distinct worlds within the hospital organization: the world of clinical care and the administrative world.

Nurse Managers and Role Satisfaction

In a marketing strategy study, the AACN reported that less than 50% of the members ranked their relationship with their Nurse Managers as a positive one (American Association of Critical-Care Nurses, 2005a). Although this is not a direct measure of NM job or role satisfaction, the serious implication is that NMs are not perceived as fulfilling some of their primary role functions – that of ensuring a positive

work environment for their staff RNs. Furthermore, NMs have reported low job preparation to meet the wide scope of their job expectations (American Association of Critical-Care Nurses, 2005a; Shirey, 2005, 2006).

Research has shown that NMs' role satisfaction is affected by their perception of support from hospital and nursing executive administration (Gaudine & Beaton, 2002; Parsons & Stonestreet, 2003; Patrick & Laschinger, 2006; Shirey, 2006; Shirey et al., 2008; Skytt et al., 2007; Thorpe & Loo, 2003). Documented areas of support NMs seek include sufficient fiscal resources to enact higher management decisions, role autonomy, role clarity, recognition of stressors within their work environment, and adequate resources to implement the organization's strategic goals (Andrews & Dziegeilewski, 2005; Anonymous, 1994; Gaudine & Beaton, 2002; Parsons & Stonestreet, 2003; Patrick & Laschinger, 2006; Shirey, 2006; Shirey et al., 2008; Skytt et al., 2007; Thorpe & Loo, 2003). However, when NMs experience organizational or other external constraints to their practice, they perceive that their performance functions are compromised in a way that negatively affects the climate of the work environment, quality of patient care, and their personal life (Gaudine & Beaton, 2002; Shirey, 2005, 2006; Shirey et al., 2008; Thorpe & Loo, 2003). This has been described as moral distress in NMs (Gaudine & Beaton, 2002; Shirey, 2006) and has been linked with NM considerations of leaving a management position, or leaving nursing entirely (Gaudine & Beaton, 2002; Shirey, 2006; Skytt et al., 2007).

The question of moral distress in NMs has been raised in the literature but there has been little specific inquiry about their experiences and the context in which moral distress arises. Because the consequences of this phenomenon can weigh heavily on some individuals, appear to affect both patient care and patient safety, and can be a contributing factor to the growing nursing shortage, a study of moral distress among NMs is needed. The following section will describe the purpose and specific aims of the study.

Statement of Study Purpose and Research Questions

Whereas the concept of moral distress is an established concept in the ethical discourse regarding the practice of clinical staff RNs, little is known about this same concept in the practice of NMs. The role of NM as mediator of the ethical climate within the hospital is suggested in the nursing administration literature even though this role activity is one that NMs necessarily assume as part of the daily management of the hospital unit. This notion is emerging in the nursing administration literature (Shirey, 2005, 2006; Shirey et al., 2008). Therefore, an articulation of NMs' experience of moral distress in the context of the hospital ethical climate will encourage a consciousness about NMs' experience of moral distress and widen the pedagogical discourse of the NM role in acute care hospitals to include the ethical domain of nursing practice, as is suggested among current scholars.

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. Given that moral distress is a natural human response to situations in which moral agency is constrained, the underlying assumption of this proposed study is that some NMs, particularly those who will choose to participate in this study, will have had an experience of moral distress.

The specific research questions for this study are:

1. What are the patterns of instances that Nurse Managers find morally distressing? How do Nurse Managers articulate the consequences of their experience of moral distress on their unit(s), to patient care, and to their own well-being?
2. How do Nurse Managers think about, understand, or verbally articulate the ways ethical issues are addressed in their role?

3. How do Nurse Managers articulate the institutional practices or attitudes that facilitate resolution of moral distress? How do Nurse Managers describe the impediments to the resolution of their experience of moral distress?

Definition of Terms

The following terms are presented for clarification pertaining to their use in this research project. They are literature derived and will drive the study method. However, consistent with qualitative methods of inquiry, the final meanings will be informed by the data.

Nurse Manager

The NM is a registered nurse employed by an acute care hospital whose primary responsibilities are to ensure that human, technological, and material resources are available to provide round-the-clock, safe, high-quality patient care in at least one acute or critical care unit (Anthony et al., 2005; Shirey, 2006).

Moral Distress

Moral distress is a process that evolves over time and is thought to result when a nurse knows the morally right course of action in a particular situation but fails to pursue that action because of internal or external constraints (Jameton, 1984; Wilkinson, 1987-1988, 1989). The context in which moral distress develops includes the ethical climate of the organization. The following section will define the components of the definition of moral distress: internal constraints, external constraints, and ethical climate.

Internal Constraints

Internal constraints are the personal attributes and characteristics (such as cognitive ability, psychological construct, personal moral values, role perception, personality, moral awareness) that are unique to each person and are formed, at least in part, by professional socialization, personal background, previous negative experiences, self-doubt, concern for reputation, lack of personal courage (Wilkinson, 1997, p. 25), moral beliefs (Cronqvist, 2004; Janvier et al., 2007), personal types of ethical decision

making and coping styles (D. A. Raines, 1994), and moral sensitivity (Erlen & Frost, 1991).

External Constraints

External constraints consist of the influential social and cultural forces within the work environment that are mediated by individual characteristics, such as internal constraints (Wilkinson, 1997, p. 25). The external constraints include intra-disciplinary relationships (for instance, relationships with physicians or administrators), laws, hospital policies, license regulations that delineate the RN scope of practice (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Wilkinson, 1997), and the social/hierarchical structure of the hospital.

Ethical Climate

A significant component of external constraints on moral action is the ethical climate of the work place. It is also described as organizational culture and is considered to be a powerful external (or institutional) constraint on resolving moral issues. Issues related to institutional thwarting of nurses' moral actions has been well-documented in the nursing literature (Ashley, 1976; Fenton, 1988; Gaudine & Beaton, 2002; Kramer, 1968, 1974; Shirey, 2006; Shirey et al., 2008). The ethical climate is generally thought to be a part of the workplace environment that is concerned with employees' prevailing perceptions of the way in which difficult situations are resolved (Olson, 1998). It is the way in which goals, missions, and values of the organization are articulated to stakeholders (the larger community, staff, patients, and students (Reiser, 1994). Communication of the ethical climate evolves through the organizational structure and typically involves issues of power, trust, and inter- and intra-professional relationships (L. Olson, 1995).

Moral Agency

Moral agency is a philosophical concept that describes the responsibilities of an individual in deciding whether to pursue an action or leave an action undone. Agency

implies an element of conscious choice, or point of view, or responsibility one person takes for actions towards another person. In this dissertation both the moral agency of the individual (the Nurse Manager) and the collective (i.e., the ethical climate) are considered.

Summary

Because the research currently available on moral distress has focused on staff RNs and a limited body of research has focused on NMs' experience of moral distress, this study will use a qualitative interpretive description design to explore NMs' perceptions of external constraints that influence their moral actions at work. This method is appropriate when the target phenomenon is not clearly understood (Sandelowski, 1993b, 2008) and facilitates development of conceptual linkages that will be grounded in the subjective nature of the phenomenon (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004).

Limited information is known about NMs' perceptions of the ethical climate and their experience of moral distress. The NM vacancy rate and expressed intention to leave a management position are significant issues not only for hospital administrative executives but also for the larger communities served by the hospital.

Nursing research in the past 25 years has shown that clinical RN responses to organizational constraints on practice result in moral or ethical stress (Corley, 1995; Corley et al., 2005; M. L. Raines, 2000; C. Ulrich et al., 2007; Zuzelo, 2007). Furthermore, another body of research has suggested that if NMs and senior administrators recognize moral distress in clinical RNs, then well-being, job satisfaction, and nurse retention could improve, which will indirectly affect the quality and safety of patient care (American Association of Critical-Care Nurses, 2006; Pendry, 2007).

Chapter II will present an integrative review of the empirical literature relevant to this study. By drawing on the literature about moral distress, ethical climate, and the role of the NM, it is intended that this proposed qualitative interpretive description study will

examine perceptions of the institutional context (specifically, the ethical climate) in which NMs experience moral distress and analyze how this context facilitates or impedes NMs' resolution of moral distress.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. Division of this chapter into two parts is reflective of the emerging scholastic imperative to transparently and methodically review, summarize, and synthesize relevant literature. Although there is a growing body of literature connecting the experience of moral distress with an organization's ethical climate among clinical staff RNs, little is known about the meanings Acute and Critical Care NMs attribute to the ethical climate of their employing hospital during incidents they describe as morally distressing.

Part I is a narrative review of the literature regarding the development of the concepts of moral distress (specifically, six core theoretical models) and the concept of an ethical climate as they effect the roles of Acute and Critical Care NMs. This literature overview has particular relevance since a majority of the moral distress and ethical climate knowledge in nursing stems from empirical nursing literature that involves clinical staff nurses, and few studies specifically target NMs' experience of moral distress in the context of the hospital ethical climate. Therefore, the narrative literature review (Part I) will serve to both situate the reader in the broader context of the literature and present the current state of the knowledge of moral distress and hospital ethical climate literature. Part II of this chapter presents a modified integrative review of the literature related specifically to NMs' perceptions of the ethical climate as it relates to their experience of moral distress. It also delineates the salient gaps in the empirical literature and further substantiates the relevance of this particular research project.

The following section constitutes Part I of Chapter II and is the narrative overview of the main concepts in this study. The narrative review begins with a description of the literature search strategy and is followed by the literature-based overviews of the three main concepts in this dissertation project: theories of moral distress, roles of the Nurse Manager, and ethical climate of a hospital organization.

Part I: Narrative Literature Review of Main Concepts

Search Strategy of the Literature

The search strategy for this narrative description of the literature is similar to the search strategy used for Part II, the modified integrative systematic literature review. The purpose of this literature search was to find empirical evidence of moral distress among hospital nurses and the influence of the hospital ethical climate on the experience of moral distress. Two general questions guided this initial search of the literature: (1)What situations produce moral distress among hospital nurses? (2) How does the ethical climate of a hospital influence the experience of moral distress?

Three search strategies were used for this narrative description of the literature to answer these two questions. The first strategy was a retrospective computer-based literature search of nursing and allied health care literature, including bioethical literature. It was conducted through The University of Iowa Hardin Library for the Health Sciences portal and The University of Iowa InfoHawk Database Catalog. The empirical literature was searched from 1960 through September 2009. The databases searched included PubMed, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Academic Search Elite, and Web of Science. The databases were searched for the terms (moral distress/stress, ethical distress/stress, job satisfaction and moral/ethical stress/distress, NM, head nurse, ethical climate, organizational climate, hospital climate) as single terms and in combinations of terms, and as concepts or subjects within each separate database. The second strategy was a hand search of the stacks at the University of Iowa Main Library and the Hardin Library for the Health Sciences for textbooks

published after the year 2000 that were relevant to the concepts. The third search strategy was of reference lists of "found" empirical papers (i.e., papers that were referenced in research articles or textbooks or in Grey Literature).

Search Results

The results of this search strategy are located in Tables II.1, II.2, and II.3 at the end of Chapter II. The following section answers the first question asked of the literature, "What situations produce moral distress among hospital nurses?" (see Tables II.1 and II.2). Answers to the second question, "How does the ethical climate of a hospital influence the experience of moral distress?" are found later in Chapter II (and Table II.3).

Studies of Moral Distress Among Hospital Nurses

Thirty-eight studies were evaluated for this narrative review. Of particular note among these moral distress studies is that a majority (27 studies) were conducted in United States. Of the 38 hospitals represented in these studies, 10 were described as either university or teaching hospitals, 5 included a mixture of types of hospitals (*i.e.,* urban, community, acute care), 1 study of a private hospital, 1 study of military nurses, and 10 studies did not report the type of hospital. No studies included hospitals with a religious affiliation. Two studies reported not-for-profit status and 36 studies did not comment on profit status. No studies reported on whether hospitals had Magnet status. Hospital bed capacity in these studies ranged from 100 to 1,250, although most studies did not report this variable. The total number of nurses studied in these 38 investigations was 3,535. Among this number were 40 NMs.

Analysis of the key results of the studies that sought to find situations that produced moral distress indicated that, in general, moral distress among staff nurses at university hospitals was associated with providing medically futile care, feeling unable to intervene in some situations, providing aggressive care that was not in the patient's best interest, or insufficient pain control (Corley et al., 2001; Davies et al., 1996; Elpern et al.,

2005; Fenton, 1988; Gutierrez, 2005; Janvier et al., 2007; McClendon & Buckner, 2007; Mobley et al., 2007; Oberle & Hughes, 2001; Rice et al., 2008).

Three studies focused on NMs (Gaudine & Beaton, 2002; Harvey, 1997; Shirey, 2008). Particular situations that led to moral distress related to insufficient staffing for patient needs, difficulty reconciling professional ethics versus organizational ethics, and issues related to cost containment (Berger, Seversen & Chvatal, 1991; Gaudine & Beaton, 2002; Harvey, 1997; Raines, 2000; Shirey, 2008).

A conclusion drawn from this analysis suggests that the situations that cause moral distress among NMs may be different from those situations that lead to moral distress among staff RNs. Studies that included NMs did not separately analyze staff RN data and NM data. This may have consequently both weakened the moral distress findings among staff nurses and hidden the moral distress findings of NMs. Thus, not only were NMs under-represented in moral distress studies, the suggestion that their experience of moral distress is different than staff nurses weakens the data that were analyzed.

The following section is a critical narrative review of the main concepts and provides relevant background information.

Moral Distress and Moral Distress Research in Nursing

The Concept of Moral Distress in Nursing

When hearing the phrase “moral distress,” most people do not understand what is meant. When the concept is explained, it is readily understood and recognized as a part of the human condition. For the purposes of this dissertation project, the author has chosen the following description of moral distress: Moral distress consists in disturbing and disruptive psychological, spiritual, and somatic responses that develop when principled ethical actions come into conflict with role expectations (Jameton, 1984; Wilkinson, 1987-1988, 1997) and arise from constraints external to the Nurse Manager’s moral agency. Moral distress can develop as the result of a situation when someone knows the

morally correct action to follow in a particular circumstance but that principled action is thwarted, usually by some external constraint. The external constraints consist of behaviors or attitudes among hospital staff that are explicitly or implicitly endorsed by the infrastructure of the organization.

Moral Distress Research in Nursing

Conceptual and Theoretical Development of Moral Distress

Although not yet termed "moral distress," the notion of nurses' experience of *being* distressed in response to constraints on their ethical decision-making has been recognized in the empirical literature for almost six decades. A broad review of nursing ethics literature (Davis, 1981; Davis & Aroskar, 1978; Holsclaw, 1965; E. M. Jones, 1962; Maryo & Lasky, 1959; Murphy, 1978; Nahm, 1940; Stein, 1968; Travelbee, 1966), and psychological literature related to nursing (Kramer, 1968, 1974) revealed that concepts congruent with moral distress, but not named as such, were described by the mid-twentieth century. They were broadly centered on patient care in the context of the nature of the nurse-physician relationship and the nurse-hospital relationship in a manner that resulted in ethical work stress and work dissatisfaction (Davis, 1981; Davis & Aroskar, 1978; Jameton, 1977; E. M. Jones, 1962; Maryo & Lasky, 1959; Miller, 1940; Nahm, 1940; Pellegrino, 1960; Stein, 1968; Travelbee, 1966). Some nurses became distressed during a moral conflict because of an inability to reconcile their personal moral obligations with constituent elements in a patient care situation (i.e., external constraints) frequently embedded within the organization. The collective moral experiences of nurses, as found in the literature, were considered within the larger notions of job satisfaction, work-related stress, and the nature of the work environment. After the distressing response was named "moral distress" in a research study by moral philosopher Andrew Jameton (Jameton, 1984), a body of empirical literature emerged. Since then, moral distress has become the subject of a growing body of research in the empirical nursing literature (Austin, 2007, p. 210; Austin, Bergum, & Goldberg, 2003; Corley & Minick,

2002; Jameton, 1984; Nathaniel, 2002, 2006; Rodney, 1988; Rodney, Doane, Storch, & Varcoe, 2006; Rodney et al., 2002; Wilkinson, 1987-1988). This body of literature includes theoretical models of moral distress and quantitative measurement tools. The next section will briefly describe the models of moral distress as they relate to this project.

Theoretical Models of Moral Distress

Most of the theoretical frameworks used in research of moral distress rest primarily on a few theoretical models. Each model considers the antecedents to moral distress, the nature of the experience of moral distress, and the consequences of moral distress. These models were developed within the nursing academy, emerged as a conversation among a few researchers, and form the foundation of the body of moral distress research.

The differences in the models appear subtle, and at times semantic, given that no research disputes the existence of moral distress but rather seeks to understand this important human experience in both qualitative and quantitative frameworks among clinical staff RNs. The models were developed through study of clinical staff RNs in an attempt, this author suggests, not only to more fully understand the ethical domain of nursing practice, but to begin to understand *what* happens to some RNs during their care of sick human beings. The missing piece in the models, particularly in the early development of the concept of moral distress, is recognition of the role that the hospital's ethical climate plays in the larger consideration of the collective experience of moral distress. Moral distress and ethical climate developed as separate phenomena despite their obvious inter-relatedness. Only recently were the concepts of moral distress, job satisfaction, and work-related stress considered together within the ethical domain of practice (Corley et al., 2005).

Primary Models of Moral Distress

Six models of moral distress appear in the literature. They are discussed in chronological order as they appeared through this literature search.

First Model

Throughout contemporary nursing ethics literature, the classical definition of moral distress is attributed to the moral philosopher/nurse ethicist, Andrew Jameton (1984). Jameton is the only non-nurse philosopher to engage in the nursing literature conversation describing the phenomenon. In his ethnographic study of nurses in a hospital in the late 1970s, he observed that in the course of their everyday practice, some nurses became visibly distressed when they could not carry out what they believed to be the right course of action for their patient(s). Noticing that these nurses had a particular relationship with their patients that differed from the relationship the physicians had with the same patients, Jameton (1984) wrote that the distress the nurses experienced was due to the inability of the nurses to act in a way that they considered consistent with the best interest (p. 5). This emotional response was labeled moral distress. The particular situations on which these observations were based were those in which nurses felt compelled to follow physicians' orders that they perceived were not necessary, such as invasive laboratory or diagnostic tests, or those that they thought would cause patients unnecessary pain (Jameton, 1984). External constraints against the moral agency of these nurses resulted in detectable psychological and physical distress.

Jameton's (1984) study expanded earlier psychology research that described the responses of newly graduated nurses in their attempt to resolve the conflicts that they encountered in their role as student nurses with idealistic notions of practice and the harsh reality of the work place (Kramer, 1974), and also among more seasoned RNs reflected through poor communication with physicians, such as the well-known "doctor-nurse game" (Stein, 1968). Nurses' responses to attempts at resolution or reconciliation of these everyday quandaries were subsequently divided into three general types: (a) moral

uncertainty, in which the moral problem lacks clarity; (b) moral dilemma, in which moral values conflict (for instance, there is no clear right answer to a problem); (c) moral distress, defined as a phenomenon that "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. 5). It is this third component of moral distress on which other studies are based and on which this proposed study is also based.

Second Model

In response to Jameton's (1984) identification of moral distress, Wilkinson (1987/1988) recognized that this experience existed within her practice of nursing. She began a body of research to further investigate the phenomenon. Wilkinson considered the source of moral distress as those everyday circumstances when nurses could not meet their primary ethical obligations to their patients (Wilkinson, 1987-1988). The intention of Wilkinson's model was to extend Jameton's work by examining the relationship between the "moral aspects of nursing and the quality of patient care" (Wilkinson, 1987-1988). This model further delineated moral distress initially described by Jameton (1984) and found that nurses' "wholeness" as human beings was compromised when they could not act morally due to the nature of the nurse-patient relationship (Wilkinson, 1987-1988). Wilkinson proposed that when nurses endure "damage to wholeness," they either leave nursing entirely or remain in the profession but continue to suffer and provide lowered quality of patient care (Wilkinson, 1987-1988).

The Wilkinson model developed from qualitative, face-to-face, question-guided interviews with 24 RNs (Wilkinson, 1987-1988). Study participants were selected by random sampling from pools of state boards of nursing. During the course of the interview process, the discovery was made that most of the nurses who responded to the survey invitation were critical care nurses. Eleven of the 24 nurses had left nursing because of an inability to cope with morally distressing situations. This observation led to further exploratory studies of moral distress in critical care nurses (Corley, 1995; Corley

et al., 2001; Fogel, 2007; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Meltzer & Huckabay, 2004; Mobley et al., 2007; Rodney, 1988; Rushton, 2006). This study was also the first documentation in the literature that nurses left nursing because of moral distress, and, importantly, it added the issue of job satisfaction to the ethical domain of nursing. Prior to these results, job satisfaction and nursing attrition literature had not identified that moral distress or ethical climate were potential explanatory factors. This absence indicates a gap in the literature and suggests a missed opportunity to explore an essential part of the nursing shortage and job dissatisfaction among nurses, thus exposing the primary role of ethics within everyday nursing practice.

In this moral distress model, Wilkinson (1987-1988) identified four dimensions of ethical behavior identified in the literature (cognitive, situational, feelings, and action) and merged these to construe the broader process of moral distress. Seven categories of moral distress indicators were found in the data: kinds of cases, frequency of moral distress, contextual constraints (such as nursing administrators' or physicians' orders), feelings, nurses' sense of wholeness, effect on patient care, and coping behaviors. Moral distress was found to cause suffering that resulted in psychological disequilibrium that eroded nurses' sense of personal wholeness through strong feelings of anger, frustration, and guilt. Wilkinson then postulated that if nurses were unable to return to wholeness, patient care would suffer because nurses would not only distance themselves from patients, both emotionally and physically, but also might leave the profession. Thus, the model described the experience and effects of moral distress on nurses' sense of wholeness and on patient care. In Wilkinson's model, moral distress arose from two different situations: (a) Nurses need to not only recognize that a moral problem exists, but also to determine the morally correct action to take; or (b) nurses recognize the problem and know the morally correct action but are unable to take that action because of external constraints (Wilkinson, 1987-1988, 1997).

Third Model

Following publication of Wilkinson's model of moral distress (Wilkinson, 1987-1988), Jameton (1993) countered with a model that distinguished between nurses' responses of feeling "puzzled" versus feeling "distressed" over the resolution of moral issues involving conflicting principles (i.e., beneficence and autonomy) in patient care situations. In the latter case, the case of becoming "distressed," Jameton argued that factors external to the nurse, such as co-workers or institutional policy, mitigated the nurses' moral judgment and rendered them "powerless" (Jameton, 1993). Citing an earlier thesis of bioethicists Beauchamp and Childress (1989), Jameton (1993) contended that distress reflects the complex social structure of the hospital environment in which ethical dilemmas and moral responsibility arise and is an important and common phenomenon. Within this model, the question of moral responsibility is the key ethical issue for understanding moral distress. Because of philosophical differences between what Jameton understood to be moral action versus moral inaction, he proposed an alteration of the definition of moral distress to include both initial distress and reactive distress. Similar to Wilkinson's definition (1987/1988), Jameton (1993) wrote that initial distress is composed of feelings of anger, guilt, and frustration that result either from dealing with value conflicts among colleagues or from bureaucratic judgments that thwart the moral judgments of the individual nurse. Reactive distress emerges when one continues to defer action, often for reasons related to powerlessness. Jameton (1993) argued that in his view, the nurse experiencing moral distress is less concerned about the resolution of competing ethical principles than with *what to do* to resolve the dilemma in the face of institutional obstacles (Jameton, 1993, p. 544).

Although several other researchers have built upon this foundational work of moral distress, no further empirical or theoretical work related to moral distress by Jameton was uncovered. The author of this project is using Jameton's (1993) postulation of the initial and reactive moral distress along with Wilkinson's (1987/1988) formulation

of nurses' disrupted sense of wholeness that is referred to as the *process* of moral distress. It is this process, alternatively described as "disrupted wholeness" by Wilkinson (1987/1988), that when linked with beliefs about the hospital's organizational infrastructure forms the experience of acute and critical care NMs that is the nexus of interest in this study.

Fourth Model

Building on both Jameton's (1984) conceptual framework of moral distress and Wilkinson's early study of moral distress (1987/1988), Corley (1995) developed the Moral Distress Scale for use with critical care and acute care staff nurses. The 32-item instrument was designed to identify issues that led to moral distress, describe the relationship between the frequency and intensity of moral distress, and identify the number of nurses who leave a position because of moral distress (Corley, 1995). Three important findings came from this study. First, the most intense levels of moral distress occurred in specific clinical situations: "giving medications intravenously to a patient who had refused to take it orally, giving only hemodynamic stabilizing medications intravenously during a 'Code Blue' with no compressions or intubation, assisting physicians who were practicing procedures on a patient after cardiopulmonary resuscitation had been unsuccessful, following the family's wishes for patient care when the nurse did not agree with them, and preparing an elderly, severely demented ('No Code') man for gastrostomy tube insertion" (Corley, 1995, p. 282-283). Second, the most frequently occurring situations that caused moral distress (participating in medically futile care) did not cause the most intense moral distress. Third, 12% of nurses in the study reported leaving a position because of moral distress. This underscores the importance of this phenomenon as a nursing and quality of care issue. However, since the scale was designed to identify clinical situations that staff nurses find morally distressing and there is a role difference between staff nurses and NMs, the scale has limited relevance for use in NMs.

Relevant subsequent moral distress research by Corley. Corley et al. (2001) conceptually furthered the Moral Distress Scale work in a study with 214 critical care nurses. Moderately high levels of moral distress were identified. Factor analysis exposed three primary and interrelated work-related sources of nurses' moral distress: interactions between the role of the nurse, patient autonomy, and institutional policies (Corley et al., 2001, pp. 254-255). Although the Moral Distress Scale was developed with and for the detection and measurement of moral distress among clinical staff nurses, the factors identified through factor analysis of the work-related sources in Corley's 2001 study arguably could extend to the role of NM in that work-related sources were identified, particularly among items related to institutional policies. This suggests a link to the concept of ethical climate if one accepts that institutional policies and regulations reflect the explicit and implicit ethical values of an organization. It is not known if concepts reflected in this scale for staff nurses fit the issues of concern to NMs. Thus, a qualitative design will be used in this study, and examination of responses will include consideration of similarities and differences to moral distress scale factors for staff nurses.

Fifth Model

Based on the notions of reactive moral distress described by Jameton (1993) and because moral distress had been identified in previous groups of nurses but not military nurses, a model of moral distress in military nursing was proposed. The rationale for this model rests on the significance of a unique military environment and the issues related to nurses' work in war deployment (Fry et al., 2002). Military nurses have unique work settings during crisis deployments (i.e., a mobile or field hospital, adverse weather conditions, unfamiliar colleagues, dangerous environments, acute battle trauma injuries, mass death, endemic diseases) and the stress associated with military triage (the least severely wounded receive treatment priority) (Fry et al., 2002, pp. 378-379.). The study participants (*n*=13) were military nurses who were either currently engaged in crisis or humanitarian missions or had been deployed in a military crisis or humanitarian mission

since 1980. The demographic characteristics of the study participants differed from the other studies in that roughly half of the participants were male (7 of 13) and the mean age (47 years) was slightly higher than is considered average among civilian nurses. Semi-structured interviews were used to gather stories, which were then taped and transcribed. Qualitative content analysis delineated 10 stories of moral distress from which a military nursing moral distress model was developed.

The process of moral distress in deployed military nurses was similar to that defined by Jameton (1993) in civilian nurses in an acute care hospital. The two key elements of moral distress, noted in the work of Jameton (1984) and Nathaniel (2002) by Austin et al. (2005) and Austin et al. (2008), include the perception of the constitutional elements of an ethical issue and the constitutional elements of the correct ethical action. These elements are also present in the military nurse moral distress process described by Fry et al. (2002). If barriers to ethical action were perceived, an initial moral distress was experienced. In the military, efforts to overcome barriers to action are made by consulting a military peer of equal rank and then in a step-wise approach with higher ranking officers. If this attempted resolution was unsuccessful, Fry et al. (2002) noticed that a reactive moral distress developed and the nurse suffered significant consequences that typically related to powerlessness and anger.

The consequences of thwarted moral action in military RNs resulted in a process similar to that described by Jameton (1993). Fry et al. (2002) described two domains of moral distress: initial military nursing moral distress and reactive military nursing moral distress. Furthermore, as in Wilkinson’s (1989) findings, military nurses experienced psychological disequilibrium and dysphoria when an ethical issue could not be resolved. Over the course of years, the military nurses described their consequent withdrawal from nursing practice, burn-out, and fear of other mission deployments (Fry et al., 2002, p. 383).

Sixth Model

Guided by a definition synthesized from the original study by Jameton (1984) and Wilkinson (1987/1988), Nathaniel (2006) developed the Theory of Moral Reckoning. The study included 21 staff nurses who, as in Wilkinson's study (1987/1988), had experienced morally or ethically distressing patient care situations. Consistent with the other theory-generating studies, participants were mostly women (20 of 21) and white (19 of 21). Sixteen of these nurses also had post-graduate degrees. The participants were recruited by advertisement in a newsletter, by word-of-mouth, and at a nursing conference. It is not known whether these nurses were clinical or administrative nurses. The interviews were not recorded, for reasons left unexplained, and the researcher was alone at each interview with the participant. Data analysis revealed that moral distress was a three-stage process, consisting of ease, resolution, and reflection, with an interruption between "ease" and "resolution" by a process termed "situational bind" (Nathaniel, 2006). During this interruption phase, the nurse was thought to be in psychological turmoil while at the same time seeming to have reconciled the conflicts between core personal values and inter-personal, professional, or organizational values and policies.

In the development of another definition of moral distress, Nathaniel (2006) incorporated the work of Jameton (1984) and Wilkinson (1987/1988) and defined moral distress as "pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse 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, either by act or omission, in a manner he or she perceives to be morally wrong" (Nathaniel, 2006, p. 421). The key definitional element added to this definition, as previously noted by Austin et al. (2005), is that the nurse *participates in the action* that he or she has already perceived as morally wrong.

Summary of Models of Moral Distress

Ethical dilemmas and moral decision-making have been discussed in nursing ethics literature for decades. However, the first documented study of moral distress, an ethnographic study of the ordinary, everyday practices of nurses by a non-nurse scholar (Jameton, 1984), uncovered the extraordinary psychological and somatic consequences for some nurses of unresolved ethical dilemmas. A research-based conversation emerged in the following decades that built on this observation, in which the attributes of moral distress were delineated and other models were proposed (Corley, 1995; Jameton, 1993; Wilkinson, 1987-1988, 1989). Wilkinson's (1987/1988, 1989) qualitative studies led to the development of the Moral Distress Equation, which was the first theoretical model to suggest antecedents to and consequences of moral distress. The issue of RNs leaving a position because of moral distress was serendipitously found by Wilkinson (1987/1988) and later verified in further moral distress research (Corley, 1995; Corley et al., 2001).

These theoretical models were developed from exploratory studies of primarily hospital-based clinical staff nurses in the United States. Except for the study from which the Moral Distress Scale emerged (Corley et al., 2001), the phenomenon of moral distress has been developed primarily through qualitative research methods. As will be apparent in Part II of Chapter II, the substantive body of empirical moral distress literature rests on the work of Jameton (1984, 1993), Wilkinson (1987/1988), and Corley (Corley, 1995; Corley et al., 2001; Corley et al., 2005). Although the Moral Distress Scale (Corley et al., 2001), a newly developed tool, helps to clarify and illuminate the phenomenon of moral distress in clinical practice, several concerns arise. Moral distress is a complex phenomenon that is part of the human experience and emerges in the moral domain of nursing practice. Because of its inherent complexity, reducing moral notions to a measurable entity seems incongruent with the essence of what constitutes a moral practice or moral sensibility. Since the Moral Distress Scale is specific to hospital-based nurses and to situations specific to acute and critical care clinical staff nurses, it has

inherent limitations outside its use among acute or critical care clinical staff nurses. This was demonstrated in the contrasting group approach validity test, which compared the Moral Distress Scale in critical care RNs with occupational health RNs (Corley, 1995).

It is important to note that there are three important assumptions upon which the Moral Distress Scale resides. These assumptions are “that nurses bring values into their work, that they can identify ethical problems in their work environment, and that they can evaluate the extent to which these problems cause moral distress” (Corley et al., 2001, p. 252) as cited by Austin et al. (2005). Although there is no question that the practice of nursing is inherently a moral practice, there is less certainty that nurses can identify ethical problems in their daily work (Austin, Lemermeyer, et al., 2005; Davis, 1981; Doka, Rushton, & Thorstenson, 1994; Oberle & Hughes, 2001) or that they can recognize the extent to which their distress is caused by unsuccessful resolution of ethical problems (Austin, Lemermeyer, et al., 2005). The evolution of the moral distress concept provides evidence that the ethical climate is an essential component of the moral distress process.

Of particular relevance to this research project is that five of the six moral distress models were generated from research with clinical staff nurses who work in acute care hospitals and one model developed from work with military nurses. NMs were not included in the study samples. Since there are significant role differences between acute/critical care clinical staff nurses and NMs, especially because NMs are charged with creating a positive work environment and because the work milieu of military nurses is incomparable with civilian nurses, there may be difficulty in extrapolating the findings to a cohort of NMs.

The thematic element of each of the models (i.e., external constraints on moral action) may contribute to the understanding of the process of moral distress in NMs. Working from the perspective that nurses’ moral action takes place within the context of the hospital social infrastructure, particularly the ethical climate of the hospital, this dissertation research will (a) examine the experience of moral distress among NMs, (b)

elicit their experience with the process of moral distress, and (c) expose their perceptions of potential external constraints on moral action in the course of their daily work. Efforts to understand moral distress among NMs must extend beyond the NMs to include the ethical climate of the work environment. The underlying concerns expressed throughout the moral distress models are the longer-term effects of moral distress on the well-being of nurses to the extent that moral distress may contribute to nursing attrition and cause nurses to deliberately avoid engaging with patients at crucial times, thus affecting patient care.

The purpose of the following section is to describe the current role of acute and critical care NMs in acute care hospitals in the U.S. This section is not a critical analysis of the empirical literature regarding roles of the NM or styles of nursing management. Rather, it is an explanatory narrative of the role of the NM in order to situate the concept within the broader context of this dissertation project. A broad understanding of the complexities of the role of the NM will add to the need to focus this research on NMs.

Role of the Acute Care and Critical Care Hospital Nurse Manager

Databases were searched for literature reviews pertaining to the role of NMs in general, and in acute/critical care hospital-based NMs in particular. The search was restricted to North American empirical literature since the two published literature reviews of the extant literature suggest differing concepts of the role of the NM outside of United States and/or Canada (Cutliffe & Lowe, 2005; Surakka, 2008). A small body of literature was found that met the review criteria.

The term *Nurse Manager* within the American system of acute care hospitals refers to registered nurses who have daily leadership and managerial responsibilities for at least one nursing unit in an acute care hospital (Anthony et al., 2005; Shirey, 2006). A NM’s domain is large and a source of occupational stress (Shirey et al., 2008; Shirey & Fisher, 2008). A recent national survey found that three quarters of NMs carry

responsibilities for at least one unit, and 20% have responsibility for more than two units (American Association of Critical Care Nurses, 2005). Critical care NMs have leadership responsibilities for an average staff size of 71 and 28 beds per unit (American Association of Critical Care Nurses, 2005).

Leadership responsibilities are those functions that address relationships in the organization (in this situation, the particular hospital unit) so as to foster an environment in which a group of people can uniformly focus on developing and enacting organizational priorities (Shirey & Fisher, 2008). Managerial responsibilities are those that concentrate on "the bottom line" so that problems that emerge in a random order throughout the day can be addressed within the organizational system (Shirey & Fisher, 2008).

Nurse Managers are strategically positioned within the organizational structure of the hospital as the link or interface between clinical bedside nurses and hospital executive administration and senior nursing administration. The role is sometimes called "pivotal" within the hospital organizational structure because NMs "pivot" between clinical nursing practice and hospital administration, and because the NMs maintain 24-hr responsibility for specific acute and/or critical care units (Anthony et al., 2005; Mathena, 2002).

Categories of Responsibilities of Acute Care and Critical Care Nurse Managers

Specific responsibilities of the NM are diverse and complex. Nurse Managers function at the intersection of organizational systems management and clinical responsibility for direct, 24-hr nursing care of acutely ill patients. A survey of the empirical literature that describes role responsibilities of the acute or critical care Nurse Manager in United States hospitals revealed four predominant management categories: human resources, financial resources, communication systems, and legal risk/regulatory agency issues (Huber, 2000; Tomey, 2009; Yoder-Wise, 2007). These categories are not

intended as discrete categories but are suggested as a general description of patterns of inter-related responsibilities. In a general sense, NM responsibilities are aligned with creating a work environment that prioritizes patient safety at the same time they are challenged to meet cost containment strategies established by hospital administration (Page, 2004). These categories suggest the strong possibility that the NM must not only meet the needs of multiple stakeholders but also attempt to reconcile the everyday ethical dilemmas that arise and do so in a way that supports the explicit values of the organization.

Human Resource Responsibilities

One of the primary responsibilities of acute care NMs is recruitment and retention of a stable cohort of clinical nurses (Andrews & Dziegeilewski, 2005; Anthony et al., 2005; Cooke, 2002; Taunton, Boyle, Woods, Hansen, & Bott, 1997; Wilson, 2005). Responsibilities related to staffing units consume “extraordinary” amounts of time (Thorpe & Loo, 2003) and draw NMs away from other activities, particularly those that are apparent to the clinical staff on the units (Shirey & Fisher, 2008; Thorpe & Loo, 2003). Creating a stable workforce of competent nurses on the unit and throughout the hospital contributes to patient safety, quality of care, and nurse job satisfaction (Aiken, Clarke, Sloane, & Consortium, 2002; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Buerhaus et al., 2007; Page, 2004). Achieving a stable workforce is difficult. These difficulties include escalating health care costs and hospital financial restructuring; an on-going nursing shortage (Buerhaus et al., 2007; Buerhaus et al., 2000b); a nursing workforce contraction (Cummings & Estabrooks, 2003); a nursing workforce that is aging (Auerbach et al., 2007; Buerhaus et al., 2000a), intergenerational (Snook, 2006; Wieck, 2007), multicultural (S. P. Clarke, 2008), and comprised of unlicensed patient care providers who work alongside registered nurses who have varying levels of experience and professional expertise (S. P. Clarke, 2008; McNeese-Smith & Crook, 2003; Sullivan & Brown, 1989).

Financial Resource Responsibilities

Over the past two decades, administrative decision-making and problem-solving have become increasingly decentralized within hospital organizations. This means that NMs have assumed greater accountability and responsibility for unit management, particularly those responsibilities related to financial management issues (Finkler, Kovner, & Jones, 2007). Financial management issues are strongly linked with resource allocation decisions, particularly allocation of scarce financial resources that must balance escalating costs associated with operating budgets and capital expenditure budgets (Finkler et al., 2007; Stafford, 2007).

Nurse Managers are positioned within two intersecting domains of hospital organizational structure: nursing and administration. Each domain has distinct ethical obligations and guiding codes of ethics. Thus, NMs are uniquely positioned to directly experience political and ethical conflict due to role complexities (Shirey et al., 2008). As registered nurses, NMs are ethically and legally bound to follow the American Nurses' Association Code of Ethics, and as part of hospital administration, they are ethically and legally obligated to follow hospital corporate policies.

Communication Within the Organization

In their pivotal position within the organizational structure of the hospital, NMs necessarily transmit key information broadly related to executing organizational policies or goals with the aim of meeting care standards and ensuring positive patient outcomes. Thus they contribute to the quality of patient care. Participation in organizational communication takes place particularly through membership on hospital committees and communication with clinical staff nurses, which is unique to each hospital organization (Huber, 2000). Various communication systems or processes (i.e., downward, chain, Y-shape, circular, or grapevine) are designed to achieve specific communication outcomes (Tomey, 2009). These systems include factors such as communication processes, interpersonal communication styles (Coeling, 2000; Huber, 2000), style of inter-

disciplinary collaboration (Huber, 2000), gender differences (Valentine, 2001), and cultural differences (Tomey, 2009). All of these factors can impede or facilitate NMs' exchange of essential information.

Legal Risk Management and Compliance With
Regulatory Agency Monitoring

Risk management comprises those activities that ensure a safe environment for patients, staff, and visitors. Concomitant with ensuring a safe environment, legal risk management and monitoring by regulatory agencies limit legal liability both to nurses and the hospital. From the perspective of NMs, these responsibilities include development of and adherence to hospital policies and procedures. They encompass transparent systems of reporting sentinel events such as errors or accidents related to diagnostic or treatment procedures, medication errors, equipment malfunction, and patient falls (Twomey, 1989). These responsibilities also include development of policies and procedures related to regulating agencies, particularly the Joint Commission on Accreditation of Health Care Organizations, the American Nurses Credentialing Center in work towards Magnet hospital status, and the Occupational Safety and Health Act (Huber, 2000; Page, 2004; Twomey, 1989).

Summary of the Role of the Nurse Manager

Nurse Managers have a key role in the day-to-day management of hospital units and face enormous performance expectations (Laschinger, Purdy, Cho, & Almost, 2006; Redman & Fry, 2003; Shirey, 2005, 2006; Shirey et al., 2008; Skytt, Ljunggren, & Carlsson, 2007). The role of NM is complex, and competence is necessary in multiple disciplines such as finance and budgeting, human resource management, conflict resolution, job satisfaction, legal risk management, information technology, and patient care issues. Furthermore, the acute and critical care environment demands the ability to respond to chaotic and frequently life-threatening emergencies that require quick

decision-making abilities to maintain a safe working environment for staff, patients, and families.

The work milieu of acute/critical health care is complex, highly technical, and costly. The role of the NM reflects the demands of this environment. Additionally, there are many ethical issues that nurses, other providers, administrators, and patients face daily. With increasing complexity of technology, escalating health care costs, cost containment strategies, and health care reform that more equitably distributes limited resources, the potential for ethical dilemmas and difficult choices for providers, consumers, and legislators continues to rise (L. L. Olson, 1995). The NM pivots between organizational administration and clinical nursing and must be strategically ready to manage multiple competing demands that have ethical consequences. Given that one of the primary roles of the NM is to create and maintain an ethical work environment, insight into NMs' perceptions of the organization's ethical climate as it relates to moral distress is critical to role fulfillment and successful unit management.

Nursing has a distinguished history of recognizing the importance of the environment, not only for the health of the patient, but also for the health, behavior, and attitudes of nurses in that environment. Nurses' perceptions of the workplace influence how work-related issues, including ethical issues, are raised and resolved. Research describing the phenomenon of moral distress illustrates the consequences to RNs' "wholeness" and well-being when the ethical issues are not successfully resolved consistent with their personal and professional ethical beliefs. Recently, nursing research has succeeded in identifying the influence of a work place variable, ethical climate, on clinical nurses' ethical practice and job satisfaction (Corley et al., 2005; Olson, 1995; C. Ulrich et al., 2007). Although the construct of ethical environment is not new to nursing (Corley & Raines, 1993; McDaniel, 1998), the concept of ethical climate as a relevant nursing practice issue is relatively new (Corley et al., 2005; McDaniel, 1998; Olson,

1995; Schminke, Ambrose, & Neubaum, 2005; Schminke, Arnaud, & Kuenzi, 2007; Shirey, 2005).

Nursing research related to the ethical work climate of hospital organizations frequently uses several surrogate concepts, which results in considerable confusion. These overlapping terms include *ethical work environment, atmosphere, climate, culture, ethical climate, organizational climate, moral climate, and organizational culture* (with an ethical or moral implication). Two reviews of these concepts, one in the nursing literature (S. P. Clarke, 2006) and one in the social sciences literature (Arnaud & Schminke, 2007), underscore the confusion. For clarification purposes, the following section differentiates these concepts to demonstrate the subtle differences between the concepts and to show how ethical climate is understood in both the moral distress/ethical climate literature and this dissertation. Following a brief discussion of organizational culture and climate, the concept of ethical climate and the results of the literature search for relevant studies will be presented.

Ethical Work Climate

Organizational Culture and Organizational Climate

Organizational culture and climate are closely related concepts that represent ways in which the meaning of the work environment is constructed by the group members through socialization processes and symbolic interaction (Reichers & Schneider, 1990). Broadly defined, *culture* is the sense of reality, the world view, or the given assumptions held by a tribe, group, society, or an organization. It is expressed through values, rituals, social, and political complexities of the group's setting (Jameton, 1990; Spradley, 1974). The meaning of culture has extended beyond anthropology into corporate or business literature, popular vernacular, and scholarly literature most notably in the 1970s and 1980s.

The following section provides a brief discussion of subcultures and moral culture to distinguish the concepts and to highlight the conceptual overlap with the larger issue of ethical climate of the hospital.

Subcultures

Normal variations exist within any larger dominant culture. Other worldviews evolve that become avenues of beliefs, norms, and behaviors for the smaller group. For instance, the culture of nursing is different from the culture of medicine, even though the primary domain of interest for both groups is "healthcare provider." The subculture of nursing is one of *care* whereas the subculture of medicine is *cure*. Subcultures exist within a larger culture of an organization, society, group, or tribe and are the unspoken assumptions or taken-for-granted parts of work that create the rituals, role expectations, social norms, values, conduct, language, and humor (Jameton, 1990).

The hospital subculture is the culture of a particular unit. It is comprised of those taken-for-granted notions, or assumptions, that frame the social structure of the unit. These assumptions are expressed in the subculture to the extent that, when they are challenged, ethical conflict arises (Jameton, 1990). For instance, as part of a larger study of the worldview of nursing-midwifery students in several Irish hospitals, data from the qualitative portion of the study (diaries and unstructured interviews) found a subculture of hierarchical subordination of the students by the nursing staff, nursing administration, and medical staff (Begley, 2002).

Moral Culture

Morality and culture are intertwined. Morality both describes and is an expression of the dominant conduct, worldview, and values of a group (Jameton, 1990). It is also a legal expression of what a group collectively expects in terms of laws, rules, and policy statements, and a social expression of what a group expects in terms of behavioral and interpersonal conduct. An example of moral subculture is the surgical theaters described in an Australian ethnographic cultural study (Gillespie et al., 2008). Operating rooms are

intense, unpredictable, critical care environments that are dependent on sophisticated technology and require intense collaboration amongst inter- and intra-disciplinary teams who necessarily work closely together under close scrutiny. The etic moral culture of surgical theaters has a distinct social order (i.e., a subculture within the hospital culture) with established moral attributes that ensure a particular social order. One conclusion of Gillespie's study suggested that those staff members who could not successfully negotiate the moral values of the subculture (such as understanding non-verbal cues, tolerating be shouted at, or coping with horizontal violence) were kept on the periphery of the unit culture and were more likely to leave their jobs (Gillespie et al., 2008).

Ethical Climate

Ethical culture is thought to constitute the *macro level* of organizational infrastructure (such as processes and management strategies) and ethical climate is thought of as the *micro level* of behavior within the organizational infrastructure (James, James, & Ashe, 1990; MacDavitt, Chou, & Stone, 2007). The ethical climate represents one dimension of the work environment that is reflective of the collective behavior of individuals (Victor & Cullen, 1987). Thus, the prevalent definition of ethical climate in the literature reflects this complex intertwining of individual moral character and the organization's implicit and explicit ethical values and moral positions (Spencer et al., 2000). This classical definition, "the shared perceptions of what is ethically correct behavior and how ethical issues should be handled" (Victor & Cullen, 1987, pp. 51-52), reflects the complex construct of ethical climate because it implies that there is a bi-directional relationship between the individual's moral character and professional values and those implicitly and explicitly declared by the organization. It is this definition that guides this dissertation. Individuals bring their own moral character and professional ethics to the organization, but there is an expectation that as employees, individuals will both learn and be socialized in accordance with the prevailing ethics of the organization to the extent that they fit into the ethical climate of the organization (Victor & Cullen,

1987). Thus, this dissertation lies at the nexus of the experience of the ethical climate and the resolution of moral distress from the perspective of NMs in the course of their everyday work.

The relevance of ethical climate as a significant work environment issue is recognized by healthcare accrediting agencies such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the American Hospital Association. Both agencies include a description of organizational ethics within their rubric of processes for ethical behavioral standards and an expectation that hospital organizations will formally address ethical climate as an important aspect of the work environment. Although JCAHO's definition of organizational ethics conveys the expectation that hospital and business practices will be conducted responsibly, honestly, decently, and properly (Joint Commission for Accreditation of Healthcare Organizations, 1997), the defining moral standards for healthcare organizations are typically drawn from the American Hospital Association Code of Ethics (American Hospital Association & Commission on Workforce for Hospitals and Health Systems, 2002). This Code of Ethics provides the basis for expected behavior of employees within the healthcare organization, in addition to the articulated policies governing the operation of the organization. The goal of organizational ethics is to integrate ethical rhetoric within the organization's stated values, mission, and vision (Hofman, 2006).

Given that the ethical climate is co-created by the organization and its employees, the relevance of the ethical climate construct is important for understanding the moral experience of nurses, particularly through the experience of moral distress. Scholars have recommended that deepening the understanding of nurses' perceptions of ethical climate will facilitate further research to develop management and interventional strategies (Corley et al., 2005; Olson, 1995; Rodney et al., 2002).

Studies of Ethical Climate and Moral Distress
Among Hospital Nurses

Twelve studies were found in the literature to answer the initial question, "How does the ethical climate of a hospital influence the experience of moral distress?" These studies are listed in Table II.3 at the end of this chapter. A majority of the studies were completed in the United States. Two studies included NMs in the sample but, like the moral distress studies, did not separately analyze their data (Pauly, Varcoe, Storch, & Newton, 2009; Penticuff & Walden, 2000). One study included social workers in the study sample (C. Ulrich et al., 2007). All of the studies found a reciprocal relationship between moral distress and ethical climate. That is, in general, moral distress more frequently occurred in environments with negative ethical climates. One study reported that ethical climate partially mediated the relationship between ethical stress (the authors' definition of moral distress) and job satisfaction (C. Ulrich et al., 2007). Further, two studies reported a negative correlation between a good ethical climate and intention to leave a job among critical care and acute care nurses (Fogel, 2007; Hart, 2005).

Three research instruments have been developed specifically to measure nurses' perceptions of a hospital's ethical climate. The following section describes current research instruments used to measure nurses' opinions about the organization's ethical climate. Table II.3 describes the specific characteristics of these three ethical climate instruments that pertain to both the systematic literature review presented in the next major section of Chapter II and to the rationale for choosing a qualitative descriptive method for this dissertation study.

Ethical Climate Theoretical Models and Research
Instruments in Nursing

Over the past 12 years, nursing scholars have offered models of hospital, or healthcare, ethical climate theories and measurement tools specifically focused on the perspectives of clinical staff nurses (e.g., Corley et al., 2005; McDaniel, 1997; Olson,

1995). These theoretical models proposed to delineate the salient ethical climate factors among clinical staff nurses, such as discussion and resolution of difficult patient care situations, and relationships with peers, supervisors, physicians, patients, and hospital administration (L. L. Olson, 1995). The models were employed in the study of nurses' perceived ethics of their employing hospital (McDaniel, 1997) and the relationship of moral distress to the ethical environment (Corley et al., 2005). The models have offered both individual factors (i.e., cognitive moral development) and organizational factors (i.e., cultural norms, behavioral codes, hospital policies and procedures, social hierarchical structure) that influence perception of ethical climate. The common thread woven through each of these models is that an ethical climate is an essential element in nurses' everyday practice. Unfortunately, none of these instruments has been tested with NMs, and it is unclear whether these instruments can capture the role expectations and nature of NMs' experience of moral distress or perception of the ethical climate.

First Model

The Ethical Environment Questionnaire (EEQ) developed by McDaniel (1997) was designed to measure ethics opinions held by a cross-section of health care providers regarding health care delivery within their health care organization. Development of the EEQ relied primarily on a review of literature from nursing ethics, health care organizational ethics, and biomedical ethical principles. There was no reference to the broader history of the ethical climate construct or the extensive business, nursing, or medical ethics literature that informed the understanding of the ethical climate of the work environment as it existed in the late 20th century. The EEQ was tested on a volunteer sample of 450 RNs from acute care hospitals in different cities from multiple Eastern states. No further description of the sample was provided.

The specific purpose of the EEQ was to measure opinions related to structures and procedures within the organization (McDaniel, 1997). The defined structures and procedures reflected elements of a health care organization's ethical climate were as

follows: participation on relevant hospital committees, sense of support from administrators and peers, and a clear understanding of organizational policies, structural organization, and moral values (McDaniel, 1997). Unlike instruments that were designed later to measure hospital ethical climates (e.g., Hospital Ethical Climate Survey) or to consider personnel relationships within the hospital environment, the EEQ solely considered the policies and procedures as indicators of an ethical work environment. Although McDaniel (1997) clearly stated that the EEQ would be a useful quantitative measure for organizational accreditation purposes (p. 904), the usefulness of the EEQ is of limited value in this dissertation project because the EEQ was not designed to understand the experience of a particular group of nurses.

Second Model

Based on Schneider's (1990) research delineating specific climate types, and strongly drawing on empirical business ethics and nursing ethics, the Hospital Ethical Climate Survey (HECS) was developed and validated to measure RNs' perceptions of the hospital's ethical climate (Olson, 1998; L. L. Olson, 1995). The convenience sample of 360 RNs, representing adult and pediatric RNs from various specialties, was drawn from two contrasting acute care hospitals in one large Midwestern city (Olson, 1998). One hospital was a religious-based, not-for-profit hospital and the second was a for-profit proprietary hospital. Reported psychometric testing of the HECS included item analysis, construct validity (by confirmatory factor analysis), convergent validity (a known measure of ethical climate was used), and internal consistency reliability (Cronbach's alpha) (Olson, 1998).

The HECS detected differences in nurses' perspectives of the ethical climate between two metropolitan hospitals in one large Midwestern city. Nurses' perspectives fell into five intercorrelated categories that described relationships between nurses and peers, managers, patients, physicians, and the hospital (Olson, 1998). Because the subscales measuring the relationships were intercorrelated, Olson (1998) wrote that the

subscales were understood to be an organizational method to measure ethical climate (p. 348). Although this instrument is an important tool for describing attributes in the ethical climate of a hospital, it appears that the ethical climate is a dynamic characteristic of a hospital that is highly dependent on the milieu of the organization's mission, purposes, and interpersonal and intraprofessional relationships.

Of particular relevance to this proposed dissertation is that only 20 of the 360 RNs sampled were NMs, whereas the overwhelming majority of the sample was staff RNs. Olson (1998) noted that the number of NMs was insufficient to detect differences or explore potential differences in perceptions of ethical climate. Therefore, the recommendation to test the instrument with more NMs is relevant to this dissertation. However, since little is known about NMs' perceptions of the ethical climate, a qualitative study would be an appropriate starting point. Although the HECS does measure nurses' perceptions of the ethical climate in a hospital organization, it does not capture perceptions of the institutional context in which moral distress is experienced, nor does it allow for an analysis of how this context facilitates or impedes resolution of moral distress.

Recognizing that those relationships existed between the ethical climate of the work environment and moral distress, Corley et al. (2001) combined the EEQ and a revision of the previously-developed Moral Distress Scale. This is explained in the following section.

Third Model

A study combining the Ethical Climate Questionnaire (McDaniel, 1997) and the Moral Distress Scale (Corley et al., 2001) captured the concept of ethical climate with moral distress by using a descriptive-correlational design to investigate inter-relationships between ethical climate of the work place, job satisfaction, and moral distress among clinical staff RNs (Corley et al., 2005). The question of whether study participants' experience of moral distress had ever caused them to leave a nursing position continued

to be raised in Corley's program of research (Corley et al., 2005). The study hypothesis proposed that moral distress is at the nexus of the complicated nimbus of social and cultural values, ethical climate of the workplace, the impact of increasingly sophisticated health care technologies, escalating health care costs, health care disparities, and the nursing shortage (Corley et al., 2005).

Similar to Wilkinson's earlier framework (1987/1988), Corley et al. (2005) considered the effect of moral distress on indicators of the quality of patient care and nurses' prior decision to leave nursing because of moral distress. This study incorporated two instruments to examine the relationships between ethical environment and moral distress. The tools used were a modified (but not psychometrically tested) Moral Distress Scale to measure moral distress frequency and intensity (Corley, 1995) and the Ethical Environment Questionnaire (McDaniel, 1997) as a quantifiable measure of the ethical environment of a healthcare practice setting. Unfortunately, the study report did not include sample size (except to say that the sample size was insufficient to allow factor analysis of the modified Moral Distress Scale), sample characteristics, questions from either questionnaire, or raw data. The correlational statistical analysis differentiated the frequency and intensity of moral distress, and importantly, showed that *being* morally distressed persists beyond the actual provoking incident. This "being" morally distressed has been labeled in the literature as moral residue by Webster and Baylis (2000) in which consequences of moral distress persist long past the actual event. Citing Webster and Baylis, Corley et al. (2005) wrote that moral residue is "what we have carried with us, powerfully concentrated in our thoughts, when we knew how we should act but were unwilling and/or unable to do so" (Corley et al., 2005). The Ethical Environment Questionnaire revealed a slightly less than positive workplace environment, particularly related to the nurses' participation in clinical ethical issues. The most frequently cited issue related to the nurses' perception of moral distress was categorized as "unsafe staffing levels" (Corley et al., 2005).

Despite the reliability limitations of the moral distress and ethical climate study by Corley et al. (2005), the particular findings that are relevant to this project are the findings that moral distress causes some RNs to leave a position and that the ethical climate of the workplace appears to influence the intensity and frequency of moral distress. This is one of the first studies that attempted to link ethical climate and moral distress. Although the consequences to patient care can only be inferred, the question of the relationship is raised. In their study, one-quarter of the sample reported leaving a previous nursing position because of moral distress (Corley et al., 2005). Furthermore, there was a higher frequency and intensity of moral distress as compared to the authors' previous work (Corley, 1995; Corley et al., 2001) and the source of that moral distress was related most often to "unsafe staffing levels" (Corley et al., 2005). The causes of the increased shift in percentage of nurses reporting leaving a position because of moral distress and the increased frequency and intensity of moral distress are not explicated in the study report. Further, the ethical environment of the hospital among this sample of nurses was not positive, and the item that scored the lowest was related to nurses' lack of involvement in ethical concerns. Corley et al. (2005) speculated that an ethical working environment would diminish both frequency and intensity of moral distress.

Recognizing the serious problems caused by moral distress and hospitals' ethical climate, a Canadian survey of hospital-based acute care RNs combined the Revised Moral Distress Scale (Corley 2001, 2005) and Olson's (1998) Hospital Ethical Climate Survey (Pauly et al., 2009). Both instruments were modified to capture contextual differences between American and Canadian health care. The intention of the cross-sectional survey was to find a correlation between moral distress and ethical climate among 1700 randomly selected acute care hospital-based RNs in British Columbia. Data analysis showed that moral distress frequency was relatively low but was accompanied by high intensity. There was a significant correlation between moral distress and ethical climate ($r = 0.412$, $P < 0.01$). This study was unfortunately limited by a low response rate

(22%) and a mismatch between survey items and ethical concerns expressed in writing by some respondents (Pauly et al., 2009). In addition to acknowledging difficulties with survey research, the authors also suggested that moral distress is experienced to the extent that it has become "normalized" and/or that experiences of moral distress have been so troublesome that completing the survey triggered difficult memories (Pauly et al., 2009). Despite these limitations, this study suggests a complex relationship between a hospital's ethical climate and the moral distress experienced by hospital-based RNs.

Summary of Part I: Narrative Review of the Relevant Literature

The purpose of Part I was to provide a literature-based survey of the main concepts in this proposed study—namely moral distress, roles of the NM, and the ethical climate of a hospital organization. The moral distress phenomenon has been well-described in the empirical literature among staff RNs for more than 20 years and rests on the work of a few scholars. In contrast, ethical climate research in the nursing academy emerged in the past decade and developed from a larger body of inter-disciplinary research, primarily found in business literature and sociology literature. A majority of the early moral distress research is based on qualitative studies that exposed a fundamental assumption related to the ethical domain of nursing practice. The assumption was that the ethical practice of nursing was the primary responsibility of each nurse and was independent of the larger ethical milieu of the hospital. The evidence for this assumption is the absence of accounting for the *milieu* in which ethical practice takes place. When the ethical climate concept emerged in the nursing academy research later in the 20th century, a connection between the moral distress response experienced by RNs and the ethical climate of the hospital organization was recognized, particularly in the most recent research by a small group of nursing scholars (Corley et al., 2005; Fogel, 2007).

Ethical climate of the work environment has been the subject of research across the disciplines of sociology, psychology, business, and health care administration for

several decades, and more recently, nursing. Tools have been developed that measure the ethical climate from the perspective of nurses for the use of administration, but no research has considered what the ethical climate actually meant to practicing RNs in the context of moral distress until the phenomenon of moral distress was described and subsequently documented as a reason for job or professional attrition. Within the past few years, nursing scholars have begun to examine the relationship between ethical climate and the experience of moral distress, particularly among staff nurses. In fact, large professional organizations such as the American Association of Critical Care Nurses and the American Nurses Association have recognized both moral distress and the ethical climate of the work place as critical practice issues.

Given that part of the responsibility for recognizing and helping to resolve ethical issues on the individual hospital units lies within the purview of the NM, knowledge about the NMs' own experience with resolution of moral problems in the context of the ethical climate of the hospital is critical. Therefore, a systematic method of examining the literature was developed. The specific literature review was undertaken to consider NMs' experience of moral distress, particularly in the context of the ethical climate of the hospital. This is presented in the next section, Part II of Chapter II.

Part II: A Systematic Method of Literature Review

Part II of the literature review used a modified integrative literature review method similar to that proposed by Whittemore and Knafl (2005). Integrative literature reviews (in contrast to other review methods that are specifically designed to elicit statistical evidence) are broadly designed to "infer generalizations from diverse sources of information about substantive issues" (Jackson, 1980, p. 438). Integrative literature review methods, particularly those in the social sciences, have developed over the past several decades (Cooper, 1982; H. Cooper, 1998; Jackson, 1980). Scholars have considered issues related to integrating evidence from diverse and emerging research methods (Cooper, 1982; Jackson, 1980; Sandelowski & Barroso, 2003; Torraco, 2005;

Whittemore & Knafl, 2005). Critics have correctly raised questions related to methodology of integrative reviews that are rooted in a lack of explicit methodologic strategies (Cooper, 1982; Jackson, 1980; Sandelowski & Barroso, 2003; Whittemore & Knafl, 2005). These review methods render the review less rigorous and thus limit a wider generalization of the review results.

In this dissertation, the integrative method was further modified to systematically find, evaluate, and synthesize the published, data-based literature describing acute care and critical care NMs' experiences of moral distress and their perception of how the ethical climate affects their ability to resolve morally distressing situations. This process exposed critical gaps in the literature and helped formulate the rationale upon which this dissertation is built. Cognizant of the methodological risks to rigor, inaccuracy, and bias specifically raised by Whittemore and Knafl (2005, p. 547) regarding literature review research within the nursing academy and by scholars outside the nursing academy (e.g., (H. Cooper, 1998; Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Dixon-Woods et al., 2007; Jackson, 1980; Jones, 2004), the goal of the process is to adhere to procedures to assure transparency and reproducibility.

The remainder of Chapter II is divided into three sections: Finding the Literature, Literature Evaluation, and Literature Synthesis. Chapter II concludes with a summary that delineates the salient gap in the literature drawing from both Parts I and II of Chapter II and leads the reader to Chapter III, the Study Method.

Finding the Literature

Guiding Questions for the Literature Review

The following four questions guided the integrative review process:

1. What situations have NMs identified that produce moral distress?

2. How do NMs perceive the ethical climate of the hospital in which they work?

3. What aspects of the ethical climate do NMs identify as impeding or facilitating resolution of morally distressing situations?

4. What concerns do NMs identify about the ethical climate or moral distress that affects their ability to fulfill their professional obligations?

A detailed grid was developed that served to retrieve and organize specific information gleaned from each study to construct the foundation of the literature review. The specific issues relevant to moral distress and ethical climate among NMs in acute care hospitals in the U.S. were sought. The specific information included the country in which the study took place, study design or method, study population sampling strategy, sample characteristics and demography, type of hospital and number of beds, profit or non-profit status, religious affiliation, Magnet status, and study results. Because the preliminary literature scoping suggested that there was little information regarding NMs specifically and that some study populations included NMs, the decision was made to search all studies that met inclusion criteria. The following section provides the background to the method used for this literature review.

Search Strategies for the Literature Review

Multiple approaches to searching the published empirical literature were taken in order to ensure a rigorous review process consistent with the integrative literature review method (Cooper, 1982; Jackson, 1980; Kirkevold, 1997; Whittemore & Knafl, 2005). The approaches included a comprehensive search of electronic databases for empirical, theoretical, and grey literature (for example, reliable lay literature such as newspapers and magazines, literature from unconventional sources such as booklets from professional organizations, or documentary films), ancestry searches through retrieved articles and literature reviews, and hand-searching two journal sets (Whittemore & Knafl, 2005). Specific search strategies suggested by several scholars were incorporated (e.g., Conn et al., 2003; Evans, 2002; Wilczynski, Marks, & Haynes, 2007). The results of the web-based search strategies (see Appendix A) include the numbers of articles that were abstracted from each search. Duplicated articles are not accounted for in the numerical listing; instead, the total number of retrieved articles is listed. The date that moral distress

began to appear in the empirical literature (1984) was chosen as the earliest date from which to search. Databases were searched from 1984 through 2008.

Inclusion Criteria

Search terms were generated based on a preliminary scoping of the literature. Additionally, a reference librarian assisted with term development and reviewed search strategies for completeness and accuracy. Inclusion criteria for the review included the following terms: (a) English language studies, (b) study samples from acute care hospitals, (c) studies of acute care or critical care NMs, or included NMs in the sample of acute care registered nurses, (d) peer-reviewed journals or doctoral dissertations, (e) primary research.

Web-based Literature Search Strategy

The web-based literature search was conducted through the University of Iowa, Hardin Library portal. Four databases were searched. Cumulative Index for Nursing and Allied Health Literature, PubMed, Academic Elite, and ABI/INFORM databases were searched using the keywords “moral distress” linked with NM, head nurse, nurse administrator, supervisory nurse, ethical climate, institutional ethics, organizational ethics, ethics, and nursing ethics. Additionally, a strategy for automatic notification of newly published articles was set up through the PubMed database.

Hand-searched Literature Strategy

Two journal sets and three nursing administration textbooks were hand-searched. The publication dates searched paralleled the web-based search strategies. The choice of which journals to search was based on a screen of reference lists from articles retrieved by the database search and scanning the shelves in the University of Iowa Health Sciences Library. The journals selected were *Nursing Ethics* (1996 – 2008) and *Journal of Advanced Nursing* (1985 – 2008) because these two journals were cited most frequently. The decision was based on the consideration that similar types of articles might be found in these journals. Three journals from each year were randomly selected

and hand-searched page-by-page for studies that captured NMs, moral distress, and/or ethical climate.

Books were also hand-searched in the stacks at The University of Iowa Hardin Library and Main Library. The strategy included an examination of the tables of contents and subject indexes for major subjects related to ethical stress, moral distress, ethical conflict, moral conflict, and ethical climate. The information from textbooks was sought under the category of "grey literature" and for references in accordance with "ancestral searches."

Grey Literature Search Strategy

Among the multiple sources of grey literature available, the decision was made to limit the search to professional organizations, Dissertation Abstracts electronic database for doctoral dissertations, books, publications of the United States government, and well-recognized newspapers. Doctoral dissertations that were subsequently published in peer-reviewed journals were not categorized as dissertations but rather as the published empirical literature for the purpose of this literature review.

Summary

However systematically this search was repeatedly executed, including consultations with an experienced health science librarian, the primary impediment that plagued the process of finding the literature was the lack of consistent terminology within and between different databases and even among scholars. That is, words such as *ethics* and *morals,* or *culture* and *climate,* or *moral distress, moral stress, ethics stress*, or evolving terminology related to descriptors of nurses, such as *head nurse, Nurse Manager,* or *nurse administrator* were inconsistently used throughout the literature and were difficult to find in database keyword searches. Therefore, all the literature had to be read carefully to discern the meanings scholars attributed to the words they used.

Although such linguistic ambiguity is not unusual in a developing body of knowledge, insufficient attention to linguistic clarity among researchers and the absence

of emerging concepts as keywords in databases diminish the reliability of a literature search (M. Clarke, 2007). An attempt to reconcile this impediment illustrates the importance of the methodological transparency of the search strategy. Repeated searches with different word combinations produced different search results. So, this particular search strategy and process of uncovering information was specifically reviewed with a health science librarian to ensure that all possible words and word combinations were used. Furthermore, with direct assistance from the librarian, literature was carefully searched for empirical evidence that met the review inclusion criteria. Therefore, the search for relevant literature was iterative and incremental, and continued until it was apparent that the same studies were consistently retrieved. In addition, literature reviews were added to the search strategy for two purposes: to read the perspectives of other scholars and to conduct an extra ancestral literature search. The results of this search are found in Appendix A, Tables A1-A4, Database Search Strategies.

Retrieved literature was read and considered for inclusion in the integrative review in the context of both the guiding questions and the pre-established inclusion criteria for this review. Literature that met the inclusion criteria was then closely studied and notes were recorded on a pre-set grid to facilitate literature evaluation and synthesis. Modification of the recorded variables on the recording grid was continued throughout the search process which necessitated further re-reading of several papers. When it was clear that all studies relevant to the inclusion criteria were found, the "found" literature was evaluated. This process is described next.

Evaluation of the Literature

This process involved two steps. The first step was to identify literature reviews and the second step was to develop a tool to collect and evaluate primary studies for the integrative review. Following consideration of relevant published literature reviews, the integrated literature review is presented.

Developing a tool for the evaluation of a collection of primary studies in the integrative review method is complex, because methodically diverse studies are included (H. Cooper, 1998; Whittemore & Knafl, 2005). That is, as data were collected and organized from each research study, patterns and themes were observed. This is similar to the method of constant comparison strategy used by Miles and Huberman (1994) as cited by Whittemore and Knafl (2005). Tables were constructed and later described that thematically organized the data in a way that answered the four guiding questions posed at the beginning of the integrative review.

General Description of Studies Considered for the Integrative Review

The purpose of the general description is to provide an overview of the numbers of studies that were initially considered for the integrative review and to describe the strategy used to arrive at the specific studies in the integrative literature review.

Fifty-two studies met the broader inclusion criteria of moral distress and/or ethical climate for the integrative literature review. Forty-eight studies were primary research papers and four were unpublished doctoral dissertations (Bamford, 1995; Fogel, 2007; Harvey, 1997; Powell, 1997). However, when the specific criteria related to NMs were applied to these 52 papers, only two published research papers (Gaudine & Beaton, 2002; Shirey et al., 2008) and one unpublished doctoral dissertation (Harvey, 1997) focused specifically on NMs. Of those three studies, moral distress was described in the two published papers. Four other studies included NMs in the study sample (Berger, Seversen, & Chvatal, 1991; Hefferman & Heilig, 1999; Penticuff & Walden, 2000; Raines, 2000) but did not separately analyze the data collected from NMs. One study focused on “nurse administrators” (Erlen & Frost, 1991) but did not delineate their job descriptions. This study was excluded since it was unclear whether NMs were considered within the role of nurse administrator. Another study focused on members of a nurse executive professional organization (American Organization of Nurse Executives; R. W.

Cooper et al., 2002), and one study focused on "nurse executives" in acute care hospitals (Sietsema & Spradley, 1987). Given that neither of these studies described the role of nurse administrators or nurse executives nor indicated whether NMs were included in the samples, the decision was made to exclude these studies from the literature evaluation to avoid the issue of sample population heterogeneity.

The final sample of studies that met the previously noted inclusion criteria of NMs (studies written in English, population sample of NMs in acute care hospitals, and studies published in peer-reviewed journals or unpublished doctoral dissertations of primary research) were three studies that are described and evaluated in the following section. The section concludes with a description and evaluation of nurse administrators and nurse executives because NMs are sometimes included within samples of nurse administrators and/or nurse executives.

<u>Description and Evaluation of Studies</u>

Three studies that investigated the experience of moral distress and perceptions of ethical climate among NMs were found. The central purpose driving each study was similarly rooted in discovering the nature of everyday experiences of NMs who strove to find a balance among competing ethical demands related to meeting organizational values, their professional ethical values, and personal ethical values. Unlike other studies considered for this integrative review, these three studies focused on the experiences that are particular to the role of the NM. Given that the goal of these studies was to develop a fuller understanding of how NMs constructed the ethical domain of their practice as it existed in their real world, these three studies appropriately used qualitative design strategies. Although there is no consistent classification standard by which qualitative research designs are judged (in a way that statistical criteria are evaluated), the critical evaluative question is whether the study design and the tradition from which the design emerges correlate (Polit & Beck, 2008). One published primary research study used a grounded theory design (Gaudine & Beaton, 2002), one used a descriptive exploratory

design (Shirey et al., 2008), and one unpublished doctoral dissertation used a phenomenology design (Harvey, 1997).

The first study, an unpublished doctoral dissertation, used an interpretive phenomenology design that considered, among other questions, the ethical conflicts routinely encountered by NMs in specific response to economic pressures to constrain health care costs and technological innovations that indirectly affect nursing practice, directly affect the NMs' practice, and further compromise a stressful role (Harvey, 1997).

The second study, conducted in Canada, examined the source of ethical conflict and the consequences of unresolved conflict among NMs. The authors described the design as a qualitative descriptive design, using a grounded theory approach to data collection (Gaudine & Beaton, 2002). However, data consisted only of interviews and there was no participant observation, which is inconsistent with the usual method of grounded theory data collection (Chiovitti & Piran, 2003; Polit & Beck, 2008). These Canadian nurse scholars, Gaudine and Beaton (2002), conducted their study for two reasons. First, they expanded the earlier work of one of the authors (Gaudine & Thorne, 2000), which described hospital staff RNs' experience of ethical conflict with their employing organization and their professional organizations. They wrote that no previous research had considered the experience of Nurse Managers. However, they did not cite an unpublished dissertation research (Harvey, 1997) that considered a similar topic. Second, at the time in which their study was planned, the province was in the midst of a provincial health care funding reorganization and system reorganization that markedly increased the scope of responsibilities faced by the NMs. Although the process of infrastructure re-organization itself, within a hospital or health care organization, is not culturally dependent, the assumption cannot be made that the ethical conflicts encountered or the ethical climate in which the restructuring takes place are culturally transcendent, because no studies have specifically considered the issue and provided evidence to dispute or

support the argument. Notable, however, is that each study was conducted during economically turbulent times in both countries.

The third chronologically published primary research study used a descriptive exploratory design and considered, among other questions, the situations that add to an already stressful NM job (Shirey et al., 2008). Interestingly, this paper did not cite Harvey's earlier work (Harvey, 1997) but did include a different Canadian study (Laschinger et al., 2004) that considered the health consequences to NMs during health care restructuring.

Given the considerable differences in health care systems among countries, the point of country of origin of the study is worth making. For instance, a study of a hospital's ethical climate recently conducted among hospital staff nurses in Turkey found that the tool developed in U.S., the Hospital Ethical Climate Survey (Olson, 1998), was not culturally sensitive because the health care delivery systems and ethical values in Turkey are much different from the American systems and values upon which the survey was developed (Bahcecik & Ozturk, 2003). Despite the fact that the three studies in this review have comparable purposes, it is likely not safe, at least given the current state of knowledge, to assume that the antecedents of moral distress or ethical climate cross cultural boundaries. Given this perspective, therefore, it is important to note that one study (Gaudine & Beaton, 2002) was conducted in an Eastern province in Canada and two studies (Harvey, 1997; Shirey et al., 2008) were done in United States.

Sampling Strategies

Evaluation of the sampling strategies followed the recommendations of Polit and Beck (2008), and addresses the key issues of sampling adequacy, appropriateness, and the extent to which findings are transferable to other similar populations (Polit & Beck, 2008, p. 360). Because the evaluation of the sampling is, in part, determined also by the study findings, the summary at the end of this section will address this specific issue. However, a critique of the sampling strategies is presented in the next section.

Each of the studies used nonprobability sampling strategies: two used convenience sampling (Gaudine & Beaton, 2002; Shirey et al., 2008) and one used a purposive sampling strategy, snow-balling (Harvey, 1997). Since qualitative research methods are concerned with discovering meaning, the goal of sample selection is to find information-rich sources (Burns & Grove, 2009; Polit & Beck, 2008). Thus, the sample selection strategies in these three studies are appropriate. Although sample size recommendations for phenomenology design method are for small samples (typically 10 or fewer participants) (Polit & Beck, 2008), Harvey (1997) included 19 hospital NMs, all of whom described situations of ethical conflict. Both qualitative descriptive studies fully described their sampling strategies and demographic characteristics. Shirey et al. (2008) included 5 NMs from one Midwestern hospital system, and Gaudine and Beaton (2002) included 15 NMs from one Eastern Canadian province.

Data Collection

The authors of each study either conducted all of the field interviews with each of the participants (Harvey, 1997) or participated in some of the interviews (Gaudine & Beaton, 2002; Shirey et al., 2008). Data consisted entirely of recorded and transcribed interviews, but no participant observation, journals, or other documents (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008). This might be expected in a study in which the authors "incorporate a grounded theory approach" (Gaudine & Beaton, 2002, p. 10). No mention was made of pre-testing the interview instrument in two studies (Gaudine & Beaton, 2002; Shirey et al., 2008). The interview instrument was pre-tested in one study (Harvey, 1997). In the interviews of all three studies, only the interviewer and the study participant were present, which likely diminishes the possibility of a participant wanting to withhold or alter information that is provided.

Findings Related to Moral Distress and Ethical Climate

Similar to the findings of moral distress and ethical climate among clinical staff RNs, and particularly the work of Jameton (1993), these three studies found that the

complex infrastructure of the hospital was the context in which NMs' moral distress arose. That is, the ethical climate was the foundation in which ethical dilemmas and moral responsibility intersected and produced the phenomenon of moral distress. However, unlike the clinical-based situations in which moral distress has been described among clinical staff RNs (i.e., Austin, Lemermeyer, et al., 2005; Corley, 2002; Hamric & Blackhall, 2007; McLendon & Buckner, 2007; Mobley et al., 2007; Nathaniel, 2006; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Tiedje, 2000; Zuzelo, 2007), the situations that caused moral distress among NMs were related to their situation of "being caught in the middle" among competing obligations to and expectations of leadership for the clinical staff RNs and hospital administration. A further difference from the moral distress and ethical climate empirical literature of NMs is that these issues have not been the focus of investigation. Instead, moral distress has been cited as a response to ethically distressing situations (e.g., Gaudine & Beaton, 2002; Shirey et al., 2008) or it has been described but not named as such (e.g., Harvey, 1997).

Gaudine and Beaton (2002) identified four themes that contributed to the development of moral distress: the sense of feeling voiceless within the organization (described also as feeling invisible and powerless), difficulties deciding how to spend limited financial resources, difficulties in balancing individual rights with organizational needs, and witnessing unjust practices of senior administrators without an avenue of recourse. Shirey et al. (2008) identified eight themes occurring in all 5 NMs in their study. One theme that emerged, "value conflicts and moral distress," caused somatic pain and psychological anguish. Although this paper did not define moral distress, the authors wrote that 4 of the 5 NMs felt manipulated by senior administration to a point described as "crossing the line" in the context of enacting financial decisions as the overriding consideration in managing their unit (Shirey et al., 2008, p. 129). Four similar themes were identified by Harvey (1997). The NMs felt caught between cost and care, experienced distress in finding fairness in decisions, felt that power should be used for

good ends, and trust is essential within the organization. The NMs were identified as having high levels of work-related stress that was exacerbated by a perception of little support from senior administration. Although moral distress was not specifically identified in this research, the thematic findings were similar to the findings of the other two studies that did include moral distress. Notable among these studies, only Gaudine and Beaton (2002) recognized the NMs' distress as moral distress despite a growing body of literature on moral distress at the time these studies were conducted. In a short description of moral distress, these authors ascribed to Jameton's (1984) definition of moral distress (Gaudine & Beaton, 2002). Furthermore, the ethical climate construct was not included in any of these studies despite its emergence in the nursing literature as a relevant practice issue. One critical interpretation of the findings of these studies is that NMs' descriptions suggest that they themselves are victims of exploitation by a system. Yet recommendations for further research by these authors did not include findings regarding NMs' experiences of ethical climate or assessments of hospital ethical climates but rather suggested the examination of NMs' stress and coping strategies (Shirey et al., 2008) as if to perpetuate the powerlessness described by NMs. Developing ways to cope with a problem system serves only to allow problems to continue and detracts attention from developing strategies to change the ethical climate.

Consequences of Moral Distress in Nurse Managers

The consequences of the process of moral distress among NMs are similar to those identified among clinical staff RNs. Wilkinson (1987/1988) wrote that nurses' wholeness is affected by moral distress to the detriment of their personal well-being and their ability or willingness to care for patients. Moreover, it is directly related to professional attrition. This theme is also present in these three studies among NMs. One exception, however, is that because NMs are not directly involved in patient care activities, no reference was made to this.

Effect of moral distress on NM well-being. Similar to the documented consequences of unresolved moral distress among clinical staff RNs, Nurse Manager well-being is also affected. Because the focus of these three studies was not moral distress, and moral distress emerged during data analysis and received only brief discussion in two of the three studies (Gaudine & Beaton, 2002; Shirey et al., 2008) and was not discussed in the third study (Harvey, 1997), the effects of moral distress are extrapolated from the findings in these studies. Somatic consequences of moral distress were described by the participants and included palpitations, headaches, and sleep disturbances (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008). Psychological consequences included decreased self-confidence, remorse, anxiety, frustration, anger, guilt, and withdrawal from family (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008).

Impact of moral distress on professional responsibilities. In these three research studies, none directly sought evidence of the impact of the ethical climate on developing or resolving moral distress. Harvey (1997) developed her study to investigate NMs' experience with ethical dilemmas. Gaudine and Beaton (2002) developed their study to evaluate NMs' perception of the ethical climate in relationship to resolving ethical conflict. Shirey et al. (2008) developed their study to evaluate the impact that the ethical climate had on NMs' fulfillment of assigned role expectations. Given their pivotal role within the acute care hospital, this is critical information to find. Although extrapolation from studies done with clinical staff RNs suggests that role fulfillment is negatively affected, the answer to this question is not clear. There is a suggestion that attempts to fulfill their complex role expectations takes a toll on NMs' well-being.

Contribution to nursing shortage. Intention to leave either a position or the profession was not a specified end-point in these three studies of NMs. However, two studies specifically noted that some NMs indicated a desire to leave a position because of moral distress (Gaudine & Beaton, 2002; Shirey et al., 2008). Of the 5 NMs interviewed

by Shirey et al. (2008), 4 were described as experiencing values conflicts with their employing hospital to the extent of unresolved moral distress. This moral distress, described in phrases such as “pushed to the point of crossing the line” regarding financial and budgetary issues, was also connected with their expressions of professional or positional attrition in order to maintain their personal and professional moral integrity (Shirey et al., 2008, p. 129). Similarly, “some” of the 15 NMs interviewed by Gaudine and Beaton also expressed “wanting to resign” as the result of moral distress. However, these NMs were said not to be able to leave their positions because of few other employment opportunities.

To comprehensively analyze the empirical literature regarding NMs’ experience of moral distress, comparable literature of nurse administrators and nurse executives is presented. The purpose of including this specific empirical literature arose from the observation that similar to studies of staff nurses, NMs are sometimes included within samples of nurse administrators and/or nurse executives. This observation was noted in an early scoping of the literature and was subsequently confirmed in finding NM literature embedded in the nursing administration or nurse executive database subject headings. The following section analyzes the literature uncovered regarding moral distress among nurse administrators, executives or leaders.

Studies of Moral Distress in Nurse Administrators, Nurse Executives, or Nurse Leaders

The concept of moral distress typically appears in the nursing administration literature in two ways. First, it appears in the context of the importance that nurse administrators should recognize moral distress in their clinical staff nurses (Fenton, 1988; Sherman, Bishop, Eggenberger, & Karden, 2007), particularly as it relates to attrition in nursing (Pendry, 2007). Second, it appears in the context of interventional strategies that nurse administrators and NMs should institute when moral distress is recognized (Rushton, 2006; Rushton & Scanlon, 1995). However, moral distress, *per se*, has not

been described in nurse administrators or nurse executives. Although several papers were found in the literature review that focused on the ethical dilemmas faced by nurse administrators and nurse executives, as well as the organizational factors that facilitated or impeded ethical decision making, no papers were found that included nurse administrators' actual response to morally distressing situations. Of particular note, these papers conceptually described morally distressing situations without linking these same encounters either to moral distress or to an outcome that directly affects their professional or personal life. *Ergo*, moral distress is not described, but rather is implied.

Seven papers in this section of the literature review are presented in Table II.3. The general intent of the papers was to identify and describe ethical dilemmas faced by nurse administrators/nurse executives. Six of the papers are descriptive survey designs (Borawski, 1995; Camunas, 1994; Cooper et al., 2002; Cooper, Frank, Gouty, & Hansen, 2003; Redman & Fry, 2003; Sietsema & Spradley, 1987) and one is a qualitative design (Katsuhara, 2005). Except for one Japanese paper (Katsuhara, 2005), the studies are American. In the six American studies, the sampling strategy for participants was a random selection through a membership list obtained from the American Organization of Nurse Executives (Camunas, 1994; Cooper et al., 2002; Cooper et al., 2003), a state board listing of registered nurses (Redman & Fry, 2003), or a state list of acute care hospitals maintained by the American Hospital Association (Borawski, 1995; Sietsema & Spradley, 1987). The Japanese study sampling strategy included both convenience and snow-balling techniques. As in previously described studies, more than 90% of the subjects in all of the studies were women. In contrast to the previously described studies of NMs and staff nurses, the age of the study participants was slightly older. Among other variables (types of hospitals, numbers of beds, profit status, religious affiliation, and magnet status), the samples between staff nurses, NMs, and nurse administrators/nurse executives were similar.

Of particular interest to this literature review is the description of “nurse administrator” and “nurse executive” used in each paper. Descriptions varied across the studies. Three papers did not describe the study subjects except as “nurse executives” (Borawski, 1995; Katsuhara, 2005; Sietsema & Spradley, 1987). Two studies (Borawski, 1995; Sietsema & Spradley, 1987) recruited subjects from statewide acute care hospitals. An assumption could be made that since the role of nurse executives likely varied both by organizational structure and hospital size, the subjects could have included NMs. Katsuhara (2005) described nurse executives as “people in top positions…who manage nursing staff or have experience working in the position” (p. 58). Again, an assumption is made that the sample could contextually refer to the North American term, “Nurse Manager.” The subjects in three papers were subsequently grouped as “middle management” or “upper management” without using the term “Nurse Manager” (Camunas, 1994; Cooper et al., 2002; Cooper et al., 2003). The subjects in one paper were described as “nurse leaders” and this was explained as head nurse, nurse supervisor, or NM (Redman & Fry, 2003). Thus, it is apparent that the concept or term “Nurse Manager” in this domain of the nursing ethics literature is vaguely defined, further increasing the difficulty of finding empirical literature describing moral distress in NMs.

The survey questionnaire used in three studies of ethical decision making in nurse administrators (Borawski, 1995; Camunas, 1994; Sietsema & Spradley, 1987) was a literature-based instrument developed by Sietsema and subsequently pretested in non-described group of nurse executives (Sietsema & Spradley, 1987, p. 28.) Details of the instrument, including validity and reliability, were not provided by Sietsema and Spradley, nor were separate publications found in the literature. This observation was not addressed in the studies that used the instrument or those that modified the instrument. The authors did not include their description of “nurse executive” for the study. Given that the questionnaires were mailed to nurse executives, verification of who completed the interview was not possible.

In the Sietsema and Spradley (1987) questionnaire, respondents were asked to choose 3 of 16 situations most frequently encountered in their practice and to choose 3 of 13 resources most commonly used to resolve their ethical dilemmas. The authors reported that less than 10% of the respondents chose the same three items regarding ethical dilemmas, and less than one-third experienced moral conflict due to competing obligations in their dual role as professional nurse and administrative executive. The categories of choices among situations that most frequently caused ethical dilemmas were reported to have fallen into the categories of resource allocation and quality of care. Sietsema and Spradley interpreted this result as an indication that nurse administrators face a wide variety of ethical dilemmas. One-third of the subjects described ethical conflict in response to deciding between morally competing obligations and responsibilities. The most frequently chosen avenue for resolution of perceived ethical dilemmas was either personal or administrative colleagues' moral values. Although the purpose of the instrument was not to explore the consequences of ethical dilemmas, neither was there mention of moral distress at a time in the literature when the concept was discussed in ethical research literature of the consequences of unresolved ethical dilemmas in nurses.

In addition to identifying ethical dilemmas, sources of ethical conflict, and resources used to resolve ethical conflict, this small group of papers did not identify whether issues were resolved or the consequences of unresolved ethical conflict. Two studies used the tool or a modification of the tool developed by Sietsema and Spradley (1987) to identify ethical dilemmas nurse executives encounter. Borawski (1995) replicated the study in a group of nurse executives in North Carolina acute care hospitals, whereas Camunas (1994) adopted portions of Sietsema and Spradley's tool in a study of nationwide members of the American Organization of Nurse Executives. Almost one-third of the subjects in these two studies reported feeling ethically conflicted as a result of trying to meet competing obligations. This is similar to the results reported by Sietsema

and Spradley. Although Katsuhara's (2005) study did not quantify the experiences of ethical dilemmas, 25 study participants related 40 stories through which 48 ethical dilemmas were analyzed. Katsuhara categorized ethical conflicts that emerged through each of the roles nurse executives held and the ethical obligations associated with each role. That is, a nurse executive is morally responsible to himself or herself as an individual, as a nurse, as a nurse executive, and as an employee of a hospital (Katsuhara, 2005).

Summary

This small group of studies among nurse executives and nurse administrators underscores the importance of studying the phenomenon of the intersection of the experience of moral distress among distinct groups of nurses. That is, the literature suggests that although the actual human response to moral distress transcends professional roles, the causes or antecedents of moral distress and perception of ethical climate may be role dependent within the hierarchical structure of the hospital. Because the NM's role within the acute care hospital pivots within the milieu of clinical practice and hospital administration, the decision to stage the review on the strength of the literature describing moral distress and ethical climate perceptions among clinical staff RNs and then investigate the literature in nurse administrators and nurse executives was a prudent decision. The initial overview of the larger body of literature revealed that NMs, as study subjects, were frequently embedded within studies of staff nurses, nurse administrators, or nurse executives. Two conclusions were drawn from this observation. First, the position and role of NM is ill-defined within the employment and hierarchical structure of nursing and the hospital, at least as it appears in the empirical literature related to moral distress and ethical climate. Second, the inclusion of NMs within the general population of a study, without clearly understanding the nuances of the differing roles of each group of nurses, particularly as this relates to NMs, may diminish the strengths of the study conclusions. Unfortunately, the body of literature at the nexus of

moral distress and ethical climate has not fully investigated the experience of NMs. Furthermore, none of the research instruments for either moral distress or ethical climate were developed for use with NMs.

The next step in this modified integrative review process is a summative synthesis of the primary sources that answer the four guiding questions posed at the beginning of the integrative literature review.

Summative Synthesis of the Empirical Literature

Two themes were identified from this modified integrative literature review. The first theme describes an interaction between NMs and the ethical domain of practice. Data in the three studies of NMs showed that the ethical domain of practice (the context in which ethical issues are recognized, discussed, and most importantly, resolved) was the virtual space essentially created by people who were hierarchically above the NMs. Thematic analysis from the three studies of NMs (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008) described NMs' perceptions of the ethical domain in recognizing that one of the NMs' roles is to balance the rights of the individual (patient or nurse) with the needs of the organization (Gaudine & Beaton, 2002), a need to trust administrators in the hospital organization to make the right decisions (Harvey, 1997), and to strive for a good relationship and communication with people in structurally higher hospital positions (Shirey et al., 2008).

The second theme describes an interaction between the ethical domain of practice that contributes to the experience of moral distress. That is, when themes of conflict emerged, a morally distressing response occurred. Themes of conflict that were described in the studies included feeling voiceless (Gaudine & Beaton, 2002) or invisible within the organization (Shirey et al., 2008), recognizing unjust practices by senior hospital administrators (Gaudine & Beaton, 2002), feeling pushed to endorse policies that the NMs did not participate in creating that cast them into morally conflicting situations (Gaudine & Beaton, 2002; Harvey, 1997; Shirey et al., 2008), such as budget allocations

(Gaudine & Thorne, 2000), or discharging patients to other less desirable institutions of care (Harvey, 1997).

Conclusion

In conclusion, research selected for this review has shown that moral distress and the ethical climate of a hospital are significant professional issues for NMs as well as for clinical staff RNs. Moral distress and the ethical climate of a hospital pose potential threats to patient care, and may be a contributing factor to a growing shortage of acute and critical care nurses and NMs. Growing evidence suggests that ethical climate plays a significant role in the process of moral distress. Although professional organizations, such as the American Nurses Association and the American Association of Critical Care Nurses, have recognized the serious practice issues that moral distress and ethical climate present to staff RNs, there has been no professional recognition of these issues posed specifically to NMs. No research was located that specifically considers NMs' perception of ethical climate and experience of moral distress.

This summary has delineated the salient gap in the empirical literature describing this current and relevant professional practice issue. Chapter III will describe the method and design of this study.

Table II.1. Question 1: What Situations Produce Moral Distress? Questionnaires and Interviews

Author	**Method**	**Variables**									**Results**
		Country	**Sampling Strategy**	**RN Sample Size**	**Mean age** / **Mean # years in practice**	**Hospital Type**	**# of beds**	**Profit Status**	**Religious Affiliation**	**Magnet Status**	
Berger, Seversen, & Chvatal, 1991	DE	USA	Random Stratified	37 staff 8 NMs	36 / 12	university	250	-	-	-	Insufficient staffing creates most moral distress
Corley, 1995	DE	USA	Purposive	111	35 / -	varied	-	-	-	-	Medical futility
Corley et al., 2001	DE	USA	Convenience	214	39 / 1-35	university	varied	varied	varied	-	Role conflict, actions not in patients' best interest, patient deception
(R. W. Cooper et al., 2002)	Descriptive	USA	Random stratified	325 members AONE	N/A	Varied	N/A	N/A	N/A	N/A	Conflict between professional ethics and organizational ethics
Elpern et al., 2005	DE (MDS)	USA	Convenience	27	41-50 / 0-30	university	-	-	-	-	Aggressive care not in patient's best interest
Janvier et al., 2007	DE	Canada (Franco-phone)	Convenience	115 RNs		3^0 care university (4 hospitals)	Large	N/A	N/A	N/A	Resuscitation of extremely low birth weight neonates

Table II.1 (continued)

Author	Method	Variables										Results
Ludwick & Silva, 2003	Online survey	Worldwide	Purposive	1,386	N/A	N/A	N/A	N/A	N/A	N/A		Nursing shortage contributed to clinical errors
McClendon & Buckner, 2007	Mixed Method (MDS)	USA	Convenience	9	38 13	urban 3^0 care University	-	-	-	-		Medical futility; staffing by NM; type of patient admitted to unit
Mobley et al., 2007	Prospective cross-sectional survey MDS	USA	Convenience	44	33 7	urban 3^0 care University	-	-	-	-		Medical futility
Perkin et al., 1997	Descriptive survey	USA	Convenience	17	N/A	N/A	N/A	N/A	N/A	N/A		Court ordered medically futile care
M. L. Raines, 2000	Descriptive, correlational, non-experimental with surveys	USA	Convenience, two tiered	22 9 (with 7 NMs)	40-50	varied	-	-	-	-		Pain management, cost containment issues, decisions in patients' best interests
Rice et al., 2008	DE MDS	USA	Convenience	260 (medical & surgical)	34 6	urban 3^0 care University	200	-	-	-		Physician practice; medical futility

Table II.1 (continued)

Author	Method	Variables									Results
Sietsema & Spradley, 1987	Descriptive Exploratory	USA	Random	125 Chief nurse Executive	-	Varied	-	-	-	-	Resource allocation; quality of care
Zuzelo, 2007	DE MDS	USA	Convenience	100	 15.24	private	500	Not for profit	-	-	Unsafe staffing; physician practice; pain control

Table II.2. Question 1: What Situations Produce Moral Distress? Qualitative Studies

Author/date	**Design**	**Variables**									**Results**
		Country	**Sampling Strategy**	**RN Sample Size**	**Avg Age** / **Avg Years in practice**	**Hospital Type**	**# of Beds**	**Profit Status**	**Religious Affiliation**	**Magnet Status**	
Austin et al., 2003	Hermeneutic interpretive	Canada	Purposive	3	-	-	-	N/A	-	N/A	Unable to meet society's expected responsibilities of care
Bamford, 1995	Grounded Theory	USA	Stratified judgment	5	25-35 /	Acute Care (urban and university)	-	Not for profit	-	N/A	"not knowing how to care"
Cronqvist, 2004	Relational Ethics	Sweden	Conven-ience	36	-	-	-	NA	-	N/A	Dissonant imperatives in ICU
Davies et al., 1996	Grounded Theory	Canada	Purposive	22	- / 7.25	3^0 care University Pediatric	-	N/A	-	N/A	Medical futility
Erlen & Frost, 1991	Descriptive	USA	Conven-ience	22 staff / 3 admin	-	-	-	-	-	-	Powerless to influence ethical decisions led to moral distress

Table II.2 (continued)

Author/date	Design	Variables									Results
		Country	Sampling Strategy	RN Sample Size	Avg Age Avg Years in practice	Hospital Type	# of Beds	Profit Status	Religious Affilia-tion	Magnet Status	
Fenton, 1988	Phenomen-ology	Canada	Conven-ience	10	-	3^0 care University	1250	N/A	-	N/A	Unable to intervene and provide dignified care
Ferrell, 2006	Descriptive	USA	Conven-ience	108	-	-	-	-	-	-	Medical futility
Fry et al., 2002	Descriptive	USA	Snow-balling	13 (6 female, 7 male)	47 -	Active military	Crisis deploy -ment	N/A	N/A	N/A	Conflict re: best interests of patient,
Gaudine & Beaton, 2002	Descriptive	Canada	Conven-ience	15	40-49 11-20	-	-	N/A	-	N/A	Distribution of resources; voiceless within organization
Gutierrez, 2005	Descriptive Exploratory	USA	Purposive	12	35 11.4	Teaching	"large"	-	-	-	Overly aggressive care; resource distribution; physicians giving inappropriate information to families
Harvey, 1997	Phenomen-ology	USA	Purposive and snow-balling	18 NMs	31-53 	Acute care	-	-	-	-	Resource distribution, being fair, use of power, trust

Table II.2 (continued)

Author/date	Design	Variables									Results
		Country	**Sampling Strategy**	**RN Sample Size**	**Avg Age** **Avg Years in practice**	**Hospital Type**	**# of Beds**	**Profit Status**	**Religious Affiliation**	**Magnet Status**	
Hefferman & Heilig, 1999	Descriptive	USA	Conven-ience	24 staff 2 NMs	- >18 yrs	Urban	“major”	-	-	-	Medical futility; unproven treatment
Holly, 1993	Descriptive	USA	Purposive	65	33 <5 yrs	Acute care	150-500	-	-	-	Powerless, medical futility, situational barriers
Kelly, 1998	Grounded Theory	USA	Conven-ience	22	25-28 1	Varied	varied	-	-	-	Not meeting own moral convictions
Krishnasamy, 1999	Descriptive Focus group	UK	Conven-ience	3	-	-	-	-	-	-	Lack of influence
Linnard-Palmer & Kools, 2005	Ethno-graph	USA	Conven-ience	20	32 2-27	Urban	“large”	_	_	_	Parental influence on treatment of children
Millette, 1994	Descriptive exploratory	USA	Purposive	24	-	-	-	-	-	-	powerlessness
Nathaniel, 2006	Grounded theory	USA	Purposive, snow-balling	21	 >10 yrs	-	-	-	-	-	Failure to morally reckon
Oberle & Hughes, 2001	Grounded theory	Canada	Nominated	14 RNs 7 MDs	 17-28	Urban	“large”	N/A	N/A	N/A	Enacting treatment disagree with

Table II.2 (continued)

Author/date	**Design**	**Variables**									**Results**
		Country	**Sampling Strategy**	**RN Sample Size**	**Avg Age** **Avg Years in practice**	**Hospital Type**	**# of Beds**	**Profit Status**	**Religious Affiliation**	**Magnet Status**	
Shirey et al., 2008	Descriptive exploratory	USA	Conven-ience	5 NMs	39-51	Urban	-	-	-	-	Feeling pushed to compromise values
Tang, Johansson, Wadensten, Wenneberg, & Ahlstrom, 2007	Descriptive exploratory	China	Conven-ience	20	32.8 14.1	Teaching Urban		N/A	N/A	N/A	Conflicting values; financial constraints; inadequate resources
Sundin-Huard & Fahy, 1999	Interpretive Interactionism (exemplar)	Australia	Purposive	10 RNs	26 new	-	-	N/A	N/A	N/A	powerlessness
Wilkinson, 1987-1988	interview	USA	Random then purposive	24 RNs	26-58 3-30	-	-	-	-	-	Medical futility, lying to patients, inadequate medical care
Wilkinson, 1989	Case study	USA	-	1	-	-	-	-	-	-	Perceived constraints

Table II.3. Studies Describing Either Ethical Climate or Interaction Between Ethical Climate and Moral Distress: Questionnaires and Interview Studies

Author/date	**Method**	**Instrument**	**Country**	**Sample Strategy**	**Sample Size**	**Key results**
Corley et al., 2005	Descriptive correlational	Moral Distress Scale Ethical Work Environment Questionnaire	USA; critical care	Convenience	106	Infrequently occurring situations cause high moral distress; powerlessness felt by AA; ethical climate score not +ve
Ells, Downie, & Kenny, 2002	Descriptive	Researcher developed questionnaire	Canada HCOs 3^0 care hospitals	Random	760 (26% rr), $1/3^{rd}$ RNs	Ethical climate of high concern, via communication
Fogel, 2007	Descriptive correlational	Moral Distress Scale; Hospital Ethical Climate Survey, Intent to Turnover (subscale of Quality of Work Life tool)	USA	Convenience , (one large faith-based hospital, one large non faith-based hospital)	100	Positive correlation between moral distress and intent to turnover; negative correlation between good ethical climate and intent to turnover

Table II.3 (continued)

Author/date	Method	Instrument	Country	Sample Strategy	Sample Size	Key results
Hamric & Blackhall, 2007	Descriptive	Moral Distress Scale (adapted); Ethical Environment Questionnaire (adapted); researcher developed questionnaire regarding end-of-life, quality of care, intra-disciplinary collaboration	USA – critical care; two hospitals (one rural, one urban)	Convenience		RNs high moral distress; negative perception of ethical climate
Hart, 2005	Cross-sectional	Hospital Ethical Climate Survey, Anticipated Turnover Scale, Nursing Retention Index	USA	Random	403	25% of turnover & 14% of intent to leave explained by ethical climate
Joseph & Deshpande, 1997	Descriptive correlational		USA	Purposive	114 RNs; 169 bed nonprofit hosp	ethical climate positively correlates with job satisfaction
McDaniel, 1998	Descriptive	Ethics Environment Questionnaire	USA	Purposive	450 RNs	Domains of ethical climate positively correlate with job satisfaction

Table II.3 (continued)

Author/date	Method	Instrument	Country	Sample Strategy	Sample Size	Key results
Pauly et al., 2009	Cross-sectional	Revised Moral Distress Scale (Corley et al, 2001; Corley et al, 2005) and HECS (Olson, 1998)	Canada	Random	374 hospital based RNs; NMs included	Low response rate; mismatch between survey items and ethical concerns; negative correlation between ethical climate and intensity of moral distress
Penticuff & Walden, 2000	Descriptive Correlational	Demographic Data Sheet; Perinatal Values Questionnaire Nursing Ethical Involvement Scale	USA	Convenience	127 NICU RNs NMs included	Resolution of moral conflict affected by ethical environment
Rathert & Fleming, 2008	Cross-sectional field study	Combination & modification of 3 previously published ethical climate survey tools	USA	Purposive	306 (low response rate)	Leadership moderates relationship between ethical climate and teamwork
B. T. Ulrich et al., 2006	Survey			Convenience	4,034	Healthy work environment affects performance (slightly <40%)
C. Ulrich et al., 2007	Survey	Researcher designed survey		Random	1,215 RNs and SWs	Ethical climate rated slightly higher than neutral; relationship between ethical stress and job satisfaction partially mediated by ethical climate

Table II.4. Qualitative Studies

Author/date	**Method**	**Country**	**Sampling Strategy**	**Sample Size**	**Key**
Gillespie et al., 2008	Ethnography	Australia	Convenience	35 RNs (plus others)	Capricious, closed environment with paradoxical social order that privileges hierarchy and technical knowledge
Silva, Gibson, Sibbald, Connolly, & Singer, 2008	Descriptive	Canada	Purposive	18 clinical ethicists	Significant organizational issue is staff moral distress due to ethical climate

CHAPTER III

RESEARCH DESIGN, METHOD, AND DATA ANALYSIS

Introduction

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. Chapter II presented the literature relevant to this question and documented that little is known about NMs' perceptions of the ethical climate in which they work or how this perception might color their experiences of incidents of moral distress. The purposes of Chapter III are to present the research method and describe strategies used to select and recruit study participants, including the inclusion and exclusion criteria, and data collection and data management. Efforts to establish the trustworthiness of the data and data analysis are presented at the end of the chapter.

Research Design

Qualitative Interpretive Description

Knowledge about human experience is, in part, generated by the art and the science of research. The kind of knowledge generated by research is reflected by the kind of research chosen to answer specific kinds of questions. If the kind of knowledge sought is the experience of the aggregate, then a quantitative research method is sought. On the other hand, if a deeper, subjective understanding of a phenomenon is sought, such as through meanings or patterns, then qualitative research is an appropriate research approach. A qualitative method of inquiry was the appropriate research approach since the aims of this research project were to further the knowledge of the subjective experience of a group of nurses, (Burns & Grove, 2001).

In the spectrum of qualitative research methods, descriptive designs both adhere less to philosophical mandates and represent a departure from the methodological orthodoxy of some other qualitative designs (Sandelowski, 2000a; Thorne, 1991). That is, other commonly used qualitative methods are historically rooted in disciplines such as education, sociology, or philosophy. In contrast, interpretive description has developed specifically within the discipline of nursing (Sandelowski, 2000a; Thorne, 1991; Thorne et al., 1997).

Analytic Framework

Although a substantial theoretical basis of moral distress has been established in the nursing literature over the past three decades and many studies have established the relevance of moral distress among clinical staff nurses, it is less established among NMs. Based on the themes that were found in the literature review in Chapter II, a qualitative interpretive description design was appropriate for this research for the following reasons. First, despite a growing body of knowledge regarding the separate concepts of moral distress and ethical climate, little information exists that describes NMs' sense of moral distress. Second, the intent of this study was to find the meanings NMs attributed to ethical climate in the context of morally distressing situations. Third, the research questions that emerged from the knowledge gaps are consistent with an inquiry method that facilitated an in-depth understanding and exploration of these important practice issues. That is, since previous research suggested that staff nurses' experience of moral distress is embedded in the ethical climate of their employing hospital, it appears that there is a complex contextual relationship between the perception of a hospital's ethical climate and the ethical domain of nursing practice. Interpretive description is one method that will accomplish these research aims by extending the purpose of qualitative description (Sandelowski, 2000a) and facilitating an interpretation and explanation of NMs' ethical domain of practice.

Interpretive description method relies on the intentional use of existing knowledge with conceptual linkages of concern, in this case moral distress and ethical climate, to logically construct new knowledge from a critical analysis of what is already known (Thorne et al., 1997; Thorne et al., 2004; Thorne, 2008). An important feature of this analytic framework is the dynamic nature of the process (Thorne et al., 1997). In this study, NMs were asked to speak about their experiences of moral distress in the context of the ethical climate of the hospital in which they worked. Through the iterative process between data collection and data analysis, the researcher maintained an open engagement with the research process and study design (Thorne et al., 1997).

Methods

Participant Recruitment

Qualitative research scholars in nursing recommend that the study sample should be appropriate to the purpose of a study (Morse, 1991; Thorne et al., 1997; Thorne, 2008) and that participants should have personal knowledge of the phenomenon along with a desire to communicate that knowledge (Sandelowski, 1995).

The convenience sample was sought through a web-based electronic discussion forum. Advertisements for study participants were placed in electronic listserves, Nurses in Healthcare Management and Business Leadership (NIHMBL), managed by the American Association of Critical Care Nurses (AACN), and the AACN electronic newsletter. The web-based LISTSERV is directed towards acute and critical care NMs. The AACN expressed an interest in posting this study (personal communication, Ramon Lavendero, R.N., MScN; September 10, 2008). The AACN was formally asked to post announcements of this study and invited potential participants to contact the researcher (see Appendix C and Appendix D). Unpublished research has demonstrated that NMs are more likely to participate in a study posted through an electronic medium than print media (personal communication, R. Lavendero, AACN; telephone conversation, September 10, 2008).

Projected Sample Size

The guiding principles that determine sufficient sample size in qualitative research in general, and in interpretive description research in particular, include considerations of the nature of the research topic, quality of the data, the breadth of the study, and the particular study design (Burns & Grove, 2009; Sandelowski, 1995; Thorne, 2008). Sample size in most interpretive description studies is typically small, between 5 and 30 participants (Thorne et al., 2004; Thorne, 2008), since the unit of analysis is the phenomenon, the number of interviews, or the number of events that describe the phenomenon (Patton, 2002; Sandelowski, 1995). Yet, the sample size must be sufficiently large so as to develop a rich understanding of the phenomenon in order to find the patterns and variations of the phenomenon and establish thematic saturation (Burns & Grove, 2009; Ezzy, 2002; Lincoln & Guba, 1985; Polit & Beck, 2008; Sandelowski, 1995). Thematic saturation was defined as the point at which no new categories are generated during the iterative process between data gathering and data analysis (Sandelowski, 2000a; Thorne et al, 1997; Thorne, 2008). Although some controversy exists in the literature regarding the philosophical understanding of the nature of saturation, it is commonly held among most qualitative researchers as the usual endpoint of sampling. The actual number of participants was determined by thematic analysis during the course of the study and was estimated to be 15 to 30 participants. Sample size in qualitative research relies on the strength of the sampling strategies and the research method to thoroughly explicate the phenomenon (Polit & Beck, 2008) and the nature of the research questions (Thorne, 2008).

Inclusion Criteria

Inclusion criteria were: (a) NMs, men or women, currently working full-time in an acute care hospital within the United States; (b) responsible for at least one acute care or critical unit; (b) English-speaking; (c) willing and able to openly discuss issues related to the ethical climate of their hospital and incidents associated with experiences of moral

distress; (d) willing to have a conversation audio recorded and transcribed (without identifying characteristics).

Exclusion Criteria

If participants met the inclusion criteria, there were no exclusion criteria.

Interviews

Interview Guide

The most commonly used data collection strategy in qualitative descriptive research is the tape-recorded interview (Thorne, 2008; Warren, 2002), and the usual strategy is a moderately structured and open-ended interview (Sandelowski, 2000a). This study used semi-structured, telephone interviews that were audio-taped.

The in-depth, open-ended interviews were based on a semi-structured interview guide. Pre-scripted questions were asked sequentially to ensure that each participant was asked the same set of questions and for each participant to describe her or his own experiences and perceptions. Efforts were made to engage each participant in the interview and to ensure clarity by asking probing questions. Other comments that opened opportunities to provide additional information or to clarify what the participant intended to say included expressions such as, “Can you give me an example of what you mean by that?’ or, “Tell me more about you mean by that,” or “What was that like for you?” or “What happened next?” (Burns & Grove, 2009). The probing questions and additional comments allowed flexibility in the interview process (Burns & Grove, 2009; Johnson, 2002). The intention of the probing questions, within the interpretive description method, was to build on pre-existing knowledge of the moral distress experience and impressions of the ethical climate of the employing hospital described by each participant. At the end of the interview, each participant was asked, “Are there things that we have not talked about, or that I have not asked, that you think I should know?” This question was included as a strategy to facilitate participants’ free engagement in the interview and gave

a temporal ending point to the interview. The interview questions with probing questions are provided in Appendix G.

The interview questions were pilot tested in telephone interviews with RN colleagues, including NMs, to rehearse the interview, refine probing questions, and estimate the length of time of the interview.

Several criteria were considered in the decision to use telephone interviews instead of face-to-face interviews in this study. Economic constraints, time available to conduct the study, and the desire to reach geographically diverse respondents prompted the initial consideration to work with telephone-based interviews. Two recently published interpretive description studies used telephone interviews along with face-to-face interviews to gather data. One study considered beliefs held by cancer patients about communication with their health care providers and disease outcome was conducted by the scholar who developed qualitative interpretive description research (Thorne, Hislop, Armstrong, & Oglov, 2008). The second study, a qualitative descriptive examination of ethical issues faced by public health practitioners conducted interviews by telephone and face-to-face (Baum, Gollust, Goold, & Jacobson, 2009).

Although some controversies exist in the literature regarding reliance on telephone interview data, the primary source of controversy arises from a methodologic precept that qualitative research interview strategies ought to include both verbal and non-verbal cues in addition to field observations that cumulatively add texture to data collection and analysis (Johnson, 2002; Warren, 2002). Because telephone interviews preclude attention to such cues, strategies were used to overcome this potential methodological weakness. In this study, the researcher used the strategy of “auditory vigilance” by listening for cues of distress, such as voice pitch and tenor, language, and background noises that prompted attention to important non-verbal cues (Tausig & Freeman, 1988). Other research has suggested that telephone interviews can facilitate respondent’s privacy and possibly encourage disclosure of information that might not

emerge in a face-to-face interview and reduce self-consciousness (McCoyd & Kerson, 2006; Tausig & Freeman, 1988).

Ethical Considerations in Interviews of Sensitive Topics

Research on moral distress or ethical climate has not previously been classified as socially sensitive. While it is not the research topic *per se* that is considered inherently sensitive, it is the *perceived* threat of consequences resulting from the research topic or wording of questions to the participant or the investigator that determines sensitivity (Lee & Renzetti, 1990). Research topics that may be socially sensitive are those that impinge on deeply personal experiences, or are concerned with deviant behavior and social control, or intrude on vested interests of powerful people or situations of coercion or dominance (Lee & Renzetti, 1990). Some descriptions in the literature of nurses' experiences of moral distress and the consequences of moral distress could be thought to be consistent with the categories of socially sensitive topics.

In previous research, NMs' stories have revealed situations of coercion or dominance by others in their employing organizations. Gaudine and Beaton (2002) reported that some of the participants in their study were visibly upset recalling events in which they had to enact hospital policies that they opposed. In a discussion of the low response rate to their survey study of moral distress and ethical climate among acute and critical care Canadian RNs, Pauly et al. (2009) reported phone calls received from potential participants regarding the "generation of troubling feeling and emotional distress" that potential participants experienced in their contemplation of completing the survey (p. 569). Shirey (2008) reported that an NM felt pressured to "cross the line" by a supervisor and was distressed by his or refusal to cooperate with the supervisor. Although not anticipated for this study, this researcher was cognizant of the potential that this research could have been considered a sensitive topic. Consideration was also given to the possibility of retribution to study participants by their employing hospital if hospitals were identifiable in the study data or report. Participants in other studies have expressed

concern about punitive actions from employers, such as being discovered and sanctioned (Dickson-Swift, James, Kippen, & Liamputtong, 2006; Frisch et al., 1990). The project was conducted according to procedures approved by the University of Iowa Institutional Review Board.

Data Management

Audiotape Transcription

Transcription of tapes has been described as pivotal to the data analysis process as it contributes to the reliability and trustworthiness of the data (MacLean, Meyer, & Estable, 2004). The interviewer transcribed the tapes verbatim to increase engagement with the data (Thorne, 2008). However, all identifying references to person and institution or organization were removed. In keeping with recommendations in the literature, "extreme care" was taken to integrate both verbal data and audio-taped but non-verbal sounds (such as sighs, laughter, sounds of crying, pauses, stuttering or false starts, and sounds of "umm" and "uhh"; MacLean et al., 2004).

Data Organization

Research Diary

A standard paper calendar-diary documented interview telephone dates, times spent on different research activities, costs of supplies related to the research, and study-related procedures, such as study-related meetings.

Management of Study Materials

A study manual, including a codebook, was maintained throughout the study. The codebook portion included definitions of codes and updates of the codes throughout the data collection and analysis period of the study. Another section of the manual included a compilation of decisions. These activities constituted the audit trail. The audit trail accounted for decisions made regarding data collection and data analysis.

Computer and Software Use

NVivo8, a computer software program, was used for data management to aid in data grouping and data structuring for analysis. The NVivo 8 program and the data were stored on a non-networked, secure computer and also on an external hard drive.

Procedures

Recruitment Strategy

Following approval by the Institutional Review Board of the University of Iowa and the AACN (Appendices C and D), an announcement of the study was published in the AACN electronic newsletter and in the AACN web-based forum, LISTSERV (Appendix E). Potential participants were invited to contact the investigator by e-mail or telephone if they were interested in participating in the study and to provide their mailing address and a telephone number so that written information could be sent.

The researcher then mailed, by standard post or electronically, a packet of study materials to each interested participant that included a study information letter (Appendix F) along with a subset of the interview questions (Appendix G). Several days after the mailing, the researcher contacted each potential participant (by their preferred method of contact) to ascertain their interest in the study (Appendix H). If the person remained interested in participating in the study, the researcher further described the research project and answered questions. If the potential participant continued to be interested in participating in the study, an interview date was set. If the potential participant declined to participate, his or her name and contact information were deleted from the research notebook. Participation in the audio-taped telephone interview constituted consent, and verbal confirmation was made at the beginning of the audio-taped interview.

Data Collection

Interviews

Each telephone interview was audio-taped, with the recorded verbal permission of the participant, on a digital voice recorder (Sony ICD-SX25VOR) and a micro-cassette

voice recorder (Sony M-570V). The digital voice recording was downloaded to a password protected personal computer and the micro-cassette tape was transcribed verbatim by the Investigator. Two recordings were made to ensure that at least one copy would be available in the event of either a power or mechanical failure. At the time of transcription, each study participant was assigned a number from a table of random numbers to ensure anonymity. Hospital names and geographic identifiers were replaced by a blank in the transcription. Following transcription, each tape was listened to on at least one further occasion by the Investigator to verify accuracy of the transcription and then on at least one other occasion in the context of subsequent interviews. Each transcription was uploaded into NVivo8 qualitative analysis software (QSR International, Melbourne, Australia) for further analysis.

Demographic Characteristics

Following each interview, participants were invited to answer demographic questions and questions regarding hospital characteristics. Information regarding participants' nursing experience, managerial responsibilities, and education were also obtained. This information was gathered to verify inclusion and exclusion criteria and to describe sample characteristics of both the participants and their employing hospitals.

Due to the population demographics of Registered Nurses throughout the United States, it was anticipated that the predominant percentage of participants would be white females residing in a metropolitan area and, on average, 42 years old (U.S. Department of Health and Human Services, 2004).

Administrative and Geographic Characteristics
of the Acute Care Hospitals

Variables identified in the literature suggested information-rich cases include hospital size, Magnet Hospital designation, hospital characteristics (university affiliation, community, rural,) profit versus non-profit taxation status, religious affiliation, and geographic location (Corley, 1998a; Corley et al., 2005; Davis & Aroskar, 1978; Fogel,

2007; Hamric & Blackhall, 2007; Olson, 1998; Rice et al., 2008). In this study, each NM – hospital formed a unique dyad. Using criteria from The Bureau of the Census, hospitals were defined with respect to population density as either rural (population ≤ 2,500), community (population 2,500 to 50,000), or urban (≥ 50,000). Hospital size varied widely (# of beds range, 81-900).

Prior to data collection, the Investigator arbitrarily divided the United States into three geographic regions for the purpose of describing the geographic location of the hospitals: West Coast (states that border the Pacific Ocean), Mid-America (states that do not border an ocean), and East Coast (states that border the Atlantic Ocean).

Documentation Procedures

Field Notes

Many qualitative research traditions incorporate field notes into data analysis to provide a scholarly record of observations or impressions as an additional source of data (Eisenhardt, 2002). Since telephone interviews precluded visual observations, field notes included auditory observations (for example, vocal or speech cues, or background noises) were written during the interview and the transcription process. In addition, hand-written field notes also included subjective observations of the actual interview process, methodological notes, and theoretical notes about data collection during the research project, informal notes of impressions, reminders, research progress, hypotheses, critical thinking, and connections among the data (Richardson, 2000). The purpose of these notes was to create a "critical epistemological stance" to open the researcher's mind to other views of reality expressed by study participants (Richardson, 2000; Thorne et al., 2008). The tapes and transcripts served as the primary source of information for this study; other field notes were considered collateral data sources to enrich interpretation and served as a reminder of unique features of each NM.

Data Analysis

The goal of qualitative interpretive description research is to develop rigorous findings that are coherent, meaningful, and satisfying reflections of how a variety of participants construct their experiences (Thorne et al., 1997; Thorne, 2008). The method of analysis provides direction for qualitative description (Sandelowski, 2000a) and at the same time extends the description of the phenomenon into interpretation and explanation (Thorne et al., 2004). The analytic objective of interpretive description is to move beyond syntactical description into creating themes and ideas that facilitate the goal of the analytic process. Extending Feldman's (1995) discussion of qualitative methodological traditions that rely on particular analytic processes to answer specific research questions, Thorne (2008) suggested that "analytic maneuvers" specific to qualitative traditions can be applicable to interpretive description studies (p. 152). Specific methods of data analysis within interpretive description methodology as proposed by Thorne (2008) were followed.

The iterative process between data collection and data analysis used in this study represents the open engagement between the researcher and the process of data collection and data analysis. This open engagement facilitates recognition of coherent themes and patterns in the data (Polit & Beck, 2008; Thorne et al., 2004). The method of data analysis in interpretive description is best described as a dynamic process because the objective of analysis is to situate the data in the body of existing knowledge of the phenomenon and extend the conceptual links of the phenomenon (Thorne et al., 2004). After the first three interviews, patterns in the interviews were identified by a preliminary analysis. This informed subsequent interviews. Recruitment and interviewing continued until new interviews consistently confirmed patterns within the thematic analysis (Thorne et al., 1997; Thorne, 2008) and data redundancy was reached. When no new codes or themes were identified, study enrollment stopped (Bakitas, 2007). Figure III.1 depicts the outline of the recruitment strategy.

Following transcription of each interview, the investigator simultaneously read the transcript and listened to the audiotape to verify accuracy of transcription. Then, each transcript was read repeatedly, along with re-readings of the field notes, to ensure a contextual understanding of "the whole." This was consistent not only with analysis of narrative transcripts in qualitative research methodology (Patton, 2002; Polit & Beck, 2008), but specifically with interpretive description (Thorne et al., 1997; Thorne, 2008).

Following multiple readings of the transcripts and field notes, the investigator scrutinized the data for clusters of ideas. Ideas and questions generated by the process were recorded in a separate code book to assist with further development of themes and categories. Thorne (2008) cautions against excessive or precise coding at this stage so that a "broad angle of vision" is developed (p. 147). The level of abstractness or concreteness cannot be determined prior to reading the transcripts, but the researcher anticipated that it would emerge after reading the first few interviews. The researcher anticipated that the initial category scheme would be based on the primary concepts, or categories, that would be identified in the literature review related to NMs' descriptions of morally distressing incidents in the context of comments about attributes of the ethical climate of their employing hospital.

Concurrent with category development, data were correspondingly coded. This iterative process ensured that no essential category was missed or mislabeled. During this process, the researcher and the dissertation chairperson met to discuss data analysis, especially related to categories, codes, and impressions.

Process of Analysis

The process of data analysis was informed by interpretive description method. The hallmark of this method is to find patterns and themes within descriptions of a phenomenon and then interpret what explains the resolution or continuation of that phenomenon (Thorne, 2008). In this particular research project, the findings include a

unifying or core theme and two subordinate themes with an interpretation of how moral distress is resolved.

Each transcript was studied on several separate occasions to find data (words or thoughts) relevant to understanding what thoughts constituted elements of an ethical climate, what situations resulted in NM moral distress, what it felt like to be morally distressed, consequences of moral distress (to patient care, to NM well-being, and to their everyday work), and patterns of resolution of moral distress. The data were "flagged" by hand with colored tags and margin notes. Specifically, the flags indicated potentially meaningful text, poignant examples given by the participants during the interview, cases or examples that were contradictory, and the Investigator's questions and insights.

A catalogue of observations was developed based on the flagged transcripts and field notes. NVivo 8 was used to manage the transcripts for analysis, to catalogue the data, and to record demographic attributes of the participants for later analysis. Through the iterative process of data collection and analysis, the catalogued data were re-conceptualized into idea clusters. Re-reading the transcripts in the context of the idea clusters facilitated the analytic process of finding the core theme and subordinate themes that unified the data. Two hand-written logs were maintained to aid the data analysis process. One log contained descriptive information about the participants that would trigger memory about each participant (for instance, age, geographic location, some specific comments by the participant). The second log, "quotable quotes," was maintained as part of the strategy recommended by Thorne (2008) to avoid over-reliance on metaphors during data analysis.

The decision to stop interviewing NMs was made when no new or "out-lying" themes of data emerged in the iterative process between interviewing and data analysis. This point was considered "saturation."

Research Rigor and Trustworthiness

Several strategies were used to ensure rigor and trustworthiness in the research process. The first strategy was to ensure coherence between the research questions, method, and process. The researcher met with the dissertation committee to discuss the research method, plans for data collection, including the interview guide and probing questions, and plans for data analysis. This limited potential bias that could have been introduced into data collection and analysis. In addition, practice interviews were conducted so that the investigator could revise questions and become familiar with the form of inquiry, develop beginning competence in qualitative interview techniques, and have familiarity with the audio-recording equipment.

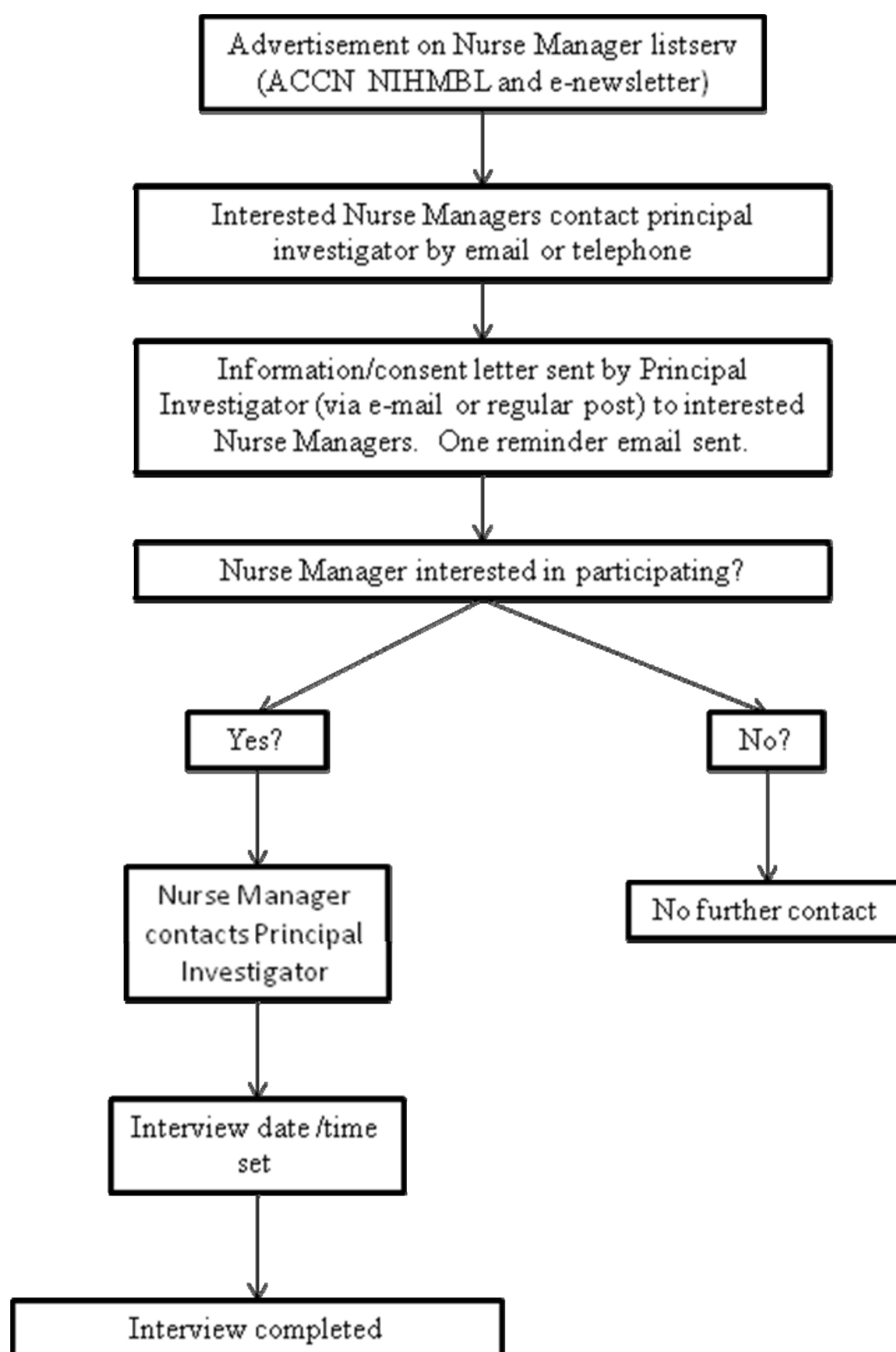
The aim of the second strategy was to ensure the integrity of the study findings. Evidence of a logical and reasoned iteration between data collection and analysis was maintained through the audit trail and data analysis. Data trustworthiness was maintained through the open engagement with the research process by transparent record keeping through the research field notes, logs, and diary (Patton, 2002; Sandelowski, 2000a). The audit trail ensured critical evaluation and transparent decision-making. Careful data analysis was composed of thick descriptions including verbatim quotes from participants (Morse, et al., 2002) and verification by the dissertation chairperson.

The aim of the third strategy was to ensure trustworthy, authoritative interpretations of the data. Careful verbatim transcripts of the interviews were studied to construct the data analysis. Participants' exact words were used except in situations where anonymity, of the participant or the hospital, was protected. In those situations, anonymous nouns were substituted (for example, "nurse," or "nurse manager," or "hospital"). Additionally, as part of the audit plan, the study procedures and a random sample of the data and data analysis were reviewed by the dissertation chairperson.

Summary

This research applied concepts of nursing administration and clinical nursing to the domain of inquiry typically reserved for nursing ethics and the broader scope of healthcare ethics. In addition to situating qualitative interpretive description method within the larger framework of the qualitative paradigm, details of the research method strategy, data interpretation procedures, and issues related to study validity and reliability have been fully described. The intention of the researcher was to ensure that evidence of the iterative nature of the research process and stepwise data analysis with its interpretation would be carefully delineated and presented in Chapter IV, Findings.

Figure III.1. Participant Recruitment Procedure



CHAPTER IV

FINDINGS

Introduction

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. The data, consisting of interviews with 17 Nurse Managers, was considered in the context of the three research questions that guided the study. The specific research questions for this study were:

1. What patterns of instances, perceived consequences to patient care, or personal well-being do Nurse Managers find morally distressing?
2. How do Nurse Managers perceive the ethical climate of their employing hospital? That is, how do Nurse Managers think about, understand, or verbally articulate the ways ethical issues are addressed in their role?
3. What institutional practices or attitudes facilitate or impede resolution of moral distress?

The purpose of Chapter IV is to present the research findings and an analysis of the findings. This chapter has three sections: demographic descriptions of the study participants and their employing hospitals, pertinent findings from the interview process, and thematic findings from data analysis.

Study Participants

There were 43 respondents to the AACN advertisements. Forty-two respondents preferred e-mail correspondence and one person requested a hard copy of the study information/consent letter by U.S. Post. Of the 43 respondents, 10 did not further reply. Of the 33 respondents to the request for an interview, 4 were ineligible (1 was an Assistant Nurse Manager and 3 were Hospital Directors), and 12 nurse managers did not

follow-up with final interview arrangements, despite one reminder email sent 2 weeks later. Telephone interviews were conducted with 17 Nurse Managers (39.5% of initial respondents). The process and results of participant recruitment is described in Figure IV.1.

Demographic Characteristics

The mean age of the sample was 46.4 years and women comprised 88% of the sample. Most of the NMs identified themselves as Caucasian, one as African-American, and one as Hispanic. Slightly more than half the NMs stated that their highest academic degree was a Master's Degree (in Business Administration, Arts, or Nursing). Slightly more than half the sample described themselves as religiously observant. Demographic characteristics of the study sample are listed in Table IV.1. The study sample size was insufficient to allow meaningful statistical analysis. There were no clear patterns of responses related to demographic responses. The information is provided to give an overview of the sample.

Geographic Characteristics

Prior to data collection, the Investigator arbitrarily divided the United States into three geographic regions for the purpose of describing the geographic location of the hospitals: West Coast (states that border the Pacific Ocean), Mid-America (states that do not border an ocean), and East Coast (states that border the Atlantic Ocean). Chance allowed for an even distribution of hospitals across the United States: 5 West Coast hospitals, 6 Mid-America hospitals, and 6 East Coast hospitals. One-third of the hospitals were affiliated with a university and one-quarter of the hospitals had a religious affiliation. There was not a clear association between NMs who described themselves as religiously observant who worked in a hospital with a religious affiliation. So, of the four hospitals with a religious affiliation, 2 of the affiliated NMs described themselves as observant of a religion. Although geographic representation was equally distributed in the study sample, the sample size was insufficient to enable meaningful statistical

comparisons. The characteristics of the hospitals are listed in Table IV.2. The administrative responsibilities of participants are described in Table IV.3. These tables are provided for descriptive purposes.

Interview Process

Interview Schedule

The sequence of interviews was the chronological order in which NMs contacted the Investigator. On one occasion, two interviews were scheduled on the same day. Generally, one to three interviews were scheduled per week over the course of approximately 10 weeks. The Investigator scheduled time between interviews to consider the interview, transcribe, read, and develop preliminary coding before conducting the next one. Each interview was scheduled on a day and time convenient for the NM. Fourteen of the 17 interviews took place during a normal working day, so the duration of the interview was an important consideration. The duration of each interview was approximately 1 hour (average 53 minutes; range, 40-70 minutes). Some of the NMs made themselves unavailable to their staff for the interview; others maintained full availability to their staff and the interviews were occasionally interrupted for a brief time.

Interview Experience

Four Nurse Managers were in the midst of a morally distressing situation at the time of the interview. They were audibly distressed during the interview as evidenced by the changing pace, rhythms, and pitch of their speech. Of the three interviews that took place outside of the NM's hospital, one NM had time constraints due to a family obligation, one NM was driving home from work, and the third NM was relaxing on a weekend morning. Thus, some NMs spoke with more emotion while other interviews seemed calm and reflective. None of the NMs reported feeling distressed at the end of the interview. Several remarked that they felt a sense of relief in talking about their experiences of moral distress.

All aspects of the interview guide, along with several probing questions, were addressed in each interview. In response to the initial question, “How have you experienced moral distress in your practice as a Nurse Manager?” several participants volunteered the recollection of a particular event. The recollection reflected a conflict with another person in their work environment (for example, issues related to a staff nurse, a physician, or someone in another department in the hospital), or situations with no immediate resolution (such as insufficient numbers of staff nurses, incompetent nurses, or severe budget constraints), or issues related to futile medical interventions in acutely/critically ill patients. Some participants were in the midst of a morally distressing situation and spoke directly to that issue. Only NM1 could not think of a situation that caused any distress, nor could this participant recall a morally distressing experience in his or her capacity as an NM.

Thematic Findings

The findings in this research are presented as a core theme and subordinate themes. The core theme, “Nurse Managers’ moral experience” is supported by three sub-themes: “experiencing moral distress through moral incongruity,” “managing moral distress: it’s such a balancing act,” and “learning to let go.” The subordinate themes have component parts that are named and described within each section. Quotes are included for each aspect of the findings and are numbered 1 to 17 to represent the 17 participants (i.e., NM1-NM17). Two disconfirming cases are included in this section.

Core Theme: Nurse Manager’s Moral Experience

The unifying or core theme identified in the data analysis was named, “Nurse Managers’ moral experience.” This theme was identified through analysis of clusters of ideas related to the participants’ views of their professional role, personal moral obligations to their work, and their perceptions of how the ethical climate of the hospital influenced their ability to fulfill their work expectations.

Data analysis suggests that the NMs experienced moral distress when they could not reconcile the professional obligations of their work with what they believed they *ought* to do. Thus, the phrase, "moral experience" is a reflection of the total ethical domain of NMs' work that includes both the professional obligations and their personal moral obligations that take place within the ethical climate of the hospital.

In the interview, participants were asked to talk about their experience of being morally distressed. The participants used illustrations of their everyday work to both begin the answer to questions and to locate the source of their moral distress. The issues described by NMs along with the characteristics of their employing hospital are shown in Table IV.4.

Evidence accumulated to show that while most of the NMs had experienced, or were currently in the midst of, a morally distressing situation, they were concomitantly balancing multiple disparate responsibilities with ubiquitous ethical components. In answering the questions about being morally distressed, one participant captured this notion. This participant said, "I face hundreds, maybe thousands, of micro [ethical] decisions every day. I'm hardly aware of them until I sit back and think about what happened today" (NM8).

The NMs' descriptions of their work confirmed the complex role obligations described in the literature. Data analysis in this study showed the NMs' roles included not only supervising staff but also ensuring that sufficient numbers of competent, healthy staff were providing safe high-quality care to the patients; ensuring staff satisfaction including addressing their stress-related issues related to burnout and turn-over; facilitating open communication with patients, families, and physicians; allocating personnel and equipment for the unit(s) within budget restrictions; implementing organizational policies; communicating with hospital administrators; and for some NMs, concomitantly caring for patients at the bedside during times when RNs were not available. Several NMs commented that their work week extended beyond their salaried

40-hour work week into evenings and weekends, interrupting personal and family time. Although some NMs referred to their work as "24/7," one participant with several years of management experience captured the essence of being an NM in the remark,

> …it's always that dilemma of trying to please, you know, the two goods… a lot of people don't realize the accountability that lies within management – that you're being responsible for safe activity and monitoring and making sure that your nurses are safe and that your patients are safe and you know, what a big responsibility that is. (NM12)

Likewise, a newly appointed NM said:

> I didn't realize how difficult it was… you know, Nurse Managers are people in the middle. You know, trying to please the budget and … patient satisfaction, and the nurse satisfaction… and you gotta enforce things that aren't really what you think are right and it's just hard. It's not an easy job. (NM6)

This comment reflects the blurred boundary between fulfilling professional ethical expectations and personal moral obligations, thus providing an insight into the broad nature of the NMs moral experience.

In answering probing questions regarding work situations, one NM built on the perspective of "being in the middle" expressed by another participant. This NM, who has many years of management experience and works in a large suburban teaching hospital, commented:

> For me, recognizing the big picture and trying to understand that, you know, part of my role is to, you know, advocate for my unit and for my staff and make sure that we have the things that we need, you know, to provide the care that we want to provide. That is, you know, that the mission's consistent with the hospital and our mission and the organization's mission. And, if we can't do that, you know, then it's my responsibility to, uh, to make sure that the people that can change that know about it and – and if they don't change it, I need to continue making sure that they understand that until something changes. And, that's my job. (NM14)

Participants' descriptions of personal moral obligations to their work were evident in their descriptions of situations they used to describe their feelings of moral distress. One NM, new to the position, said,

> …number one, our mission is to ensure that our patients are well taken care of. The second part of our mission is to ensure our staff are well taken care of …that their needs are met, and we give them the tools that they need to succeed…if they're dissatisfied, I need to …fix that. I'd say it's not a burden, it's a weight on

> me. It's just part of my job. It's part of my obligation and what I signed up for. (NM16)

All of the participants described a moral commitment to patient care on their unit(s) that did not end when they physically left the hospital, an indication of the personal moral obligation to their work. One participant, who has been responsible for a busy obstetrical unit for 10 years said, "I'm somebody that takes that 24 [hour], 7 [day] responsibility very seriously" (NM9). Another NM, with little experience in management and only a few years as a staff nurse, recently opened a sub-specialty ICU in a university-affiliated hospital. The ICU was recently nationally recognized for outstanding medical and nursing care. However, this participant continued to carry NM responsibilities after physically leaving the hospital as evidenced in the comment, "…ultimately, the manager has full responsibility – 24[hour], 7[day] responsibility for a given area…anything that transpires in that area is a direct reflection on that manager" (NM2). Another NM, with little management experience and many years as a staff nurse, said, "You know, I care about people. And, I want to know that what I do makes a difference. That's what drives me to do this and do it all the time…it's the compassion and the wanting to make people feel better" (NM6).

Fulfillment of these frequently competing professional ethical responsibilities and personal moral obligations appears to require a morally congruent ethical climate. The first subtheme, in the following section, describes NMs' perceptions of the ethical climate in which they work and their sense of moral distress when components of the ethical climate are not congruent with their professional ethical and personal moral obligations to their work.

Sub-theme I: Experiencing Moral Distress Through Moral Incongruity

Moral distress does not appear to erupt in response to one single event, but rather appears to be the result of a pattern of managing concomitant situations, or the same kind of problem repeatedly, within the context of the ethical climate of the hospital and the

NM's own personal values. The notion of moral incongruity was identified in the data when there was a "mismatch" between the implicit moral character and professional values of the participants and the implicit ethical values and moral positions of the hospital organization. Implicit values are those that are enacted by people working within the hospital. Explicit values are those that are written by an organization and include documents such as mission statements, core values, and "rights." Ethical climate, as discussed in the literature review (Chapter II), is a complex intertwining of individual moral character and the organization's implicit and explicit ethical values and moral positions (Spencer, Mills, Rorty, & Werhane, 2000).

The experience of moral incongruity arose when NMs' expectations of how situations ought to be handled conflicted with the hospital's implicit (enacted) values and moral positions. That is, moral incongruity arose within the ethical climate of the hospital. For the NMs in this study, it appears that unresolved moral incongruity led to their experience of moral distress. The sources of moral incongruities that led to moral distress included negative interactions with hospital administrators/enacting policies they disagreed with, issues related to staff nurses, and poor behavior by physicians. Each of these sources of moral incongruity that led to the experience of moral distress provided evidence of the ethical climate of the hospital.

The following section describes findings from the data that illustrate the notion of moral incongruities that led to participants' self-described moral distress. These findings were divided into three sources: administrative departments/policies, concerns about nursing staff, and interactions with physicians. Exemplars are provided for each section.

Moral Incongruity With Administrative Policies

Several NMs spoke about moral incongruities they experienced regarding having to enact hospital policies that they fundamentally disagreed with. The ramifications of enacting the policies were far-reaching and led to moral distress. Most frequently, the

conflict related to inflexible Human Resource policies related to discipline policies, "floating policies," lack of ethics resources, and sick leave for staff.

Addressing the issue of their experience of moral distress, one participant said it has to do with organizational policies, particularly related to discipline:

> We have systems in place to make the …whole organization work. And sometimes they [the policies] are in conflict with what a manager knows is the right thing to do with an employee…we have to base decisions on those rules and policies even though ethically and morally we know that they are not correct. (NM7)

NM7 continued to explain that an experienced and excellent staff nurse had a lapse in judgment that was due to "burn out." Due to the current hospital policy, this participant was forced to put a label on the staff's employment record that would never be removed and would prevent that staff nurse from acting as a preceptor. The participant argued with human resources that application of the policy in that instance was inappropriate and that this was a Nursing issue not a human resources issue. The NM further argued that although everyone should be held accountable for their actions, the NM should "have the right to alter the rules." This NM experienced continued moral distress that resulted from having to enact policies that thwarted the NM's professional ethical responsibilities.

Floating policies. Many NMs spoke about the effects of the nursing shortage in their hospitals. To meet the hospital's mission statements related to providing patient care in spite of insufficient numbers of RNs, staff nurses are required as a matter of policy to "'float" to other units. While different hospitals have different policies regarding a "floating policy," it remains a common problem according to the participants in this study.

The NMs spoke about the considerable strain a "float" policy puts on both the staff nurses and themselves; in addition, it puts a risk on patients who may have a staff nurse working outside their scope of expertise. That is, RNs who float to critical care units are frequently not critical care RNS, and, in some hospitals, staff who are floated to

critical care units are not RNs but are unlicensed nurses' aides. These unlicensed nurses' aides are not providing critical care nursing tasks but are helping with basic bedside care. However, this means that the staff RNs and the NMs have unlicensed staff to supervise in addition to caring for critically ill patients and their families. One NM, who has more than two decades of management experience said, "We are getting non-critical care support staff to help out with the non-critical issues….So, I take over one less critically ill patient, direct the float support staff, and have to leave my other work for another time" (NM17). Another NM, who had not practiced at the bedside for several years, was equally distressed by a new floating policy at the hospital. In response to a nursing shortage at the hospital, this participant was required to assume direct patient care responsibilities in addition to daily management responsibilities:

> I think hospitals still want to say, 'well, you're the last resort. You need to go in and fix it.' And in critical care, more than anywhere. I haven't done bedside nursing in more than 12 years. You don't want me to be your critical care nurse. And, I don't want to be your critical care nurse. That's not where I need to put my energy. I need to put my energy into finding the appropriate staff to care for you. (NM7)

One NM, who works in a community hospital, reported that the floating policy is determined by a Nursing administrator who looks at the nurse-patient ratio and makes a decision to float nurses either away from the Unit or to the Unit. "It's just based on numbers" (NM12). This NM continued by saying that the continuous strain of having to "juggle nurses between patients" to ensure patient safety had caused him or her to become morally distressed to the extent that the NM was planning to resign at the end of the second year of employment.

Another NM, who works in a small rural hospital and has more than a decade of management experience, described a similar problem with the hospital floating policy but framed it in a different way: "I have to remember that it [floating policy] is not just my Department. This is hospital wide. And, they're trying to look at the whole good of the organization" (NM5).

Illness policies. Several NMs spoke about nurses on their staff who suffered effects of chronic illness. These NMs spoke about the moral conflict they felt in asking, or allowing, their staff nurses to work overtime and potentially risking their health during periods of being short-staffed. They spoke about how to accommodate the specific health needs of staff nurses without appearing to either show favoritism or compromise the privacy of the staff nurse with other staff. However, a poignant example was given by NM3 who has many years of management experience. This NM described the situation with a staff nurse who had taken the maximum number of sick time allowed by the hospital, even with the Medical Leave Act. The staff nurse, a single parent, had no other source of income. Since the treatment of the illness required more time off from work, the Human Resources department required that the staff nurse's position be terminated unless the staff nurse could arrange to work between treatments. NM3 had to enact this policy, and moral distress arose in an inability to reconcile his or her own moral values with the extrinsic and intrinsic values of the hospital:

> I have to tell her she no longer has a position… and then, of course, she'll lose her health care insurance and everything… as for my hospital, what should they do? Well, we (in United States) should have socialized health care and not have – and health care shouldn't be attached to the job… y'know, it comes down to money and if they [hospital administration] make an exception for my nurse, y'know, then, how do they not make an exception for the nurse with a rotator cuff who just thinks she needs 6 more weeks off? … I truly don't know what the best answer is… but it distresses me. (NM3)

In some circumstances, staff illnesses not only coincided with illness policies but with staff shortages and budget restrictions. This situation is described by NM13, who was a new NM in a new hospital. Due to budget restrictions and staff nurse shortages, NM13 had to assume care for patients in addition to other management responsibilities. The participant described the ICU staff as being a closely knit group. During a particularly busy period in the ICU, NM13 was not allowed to pay staff nurses over-time or hire more nursing staff. The NM explained that one of the ICU staff nurses, who was in the midst of a lengthy illness leave from work, called and offered to come in to help.

The participant related his or her thoughts about how to reconcile the directive from hospital administration that discouraged paying over-time for staff nurses or hiring another staff nurse with allowing an ill staff member to come in to work and having to take on the responsibility of patient care:

> You know, I have a full assignment but we're managing. I don't want [staff nurse] to come in …because I know [he or she] worked last week and I don't want [him or her] to get sick. …so, I let [him or her] come in. You know, and so there's that – that balance. I mean, I know [staff nurse]. I know that [he or she] would come in if I told [him or her]. [He or she] would come in every single day of the week. But then [he or she] would end up – you know, [he's]or [she's] got [chronic disease]. [He or she] would end up very sick (NM13)

<u>Lack of ethics resources</u>. During a discussion of issues that resulted in moral distress, the data showed that almost half of the participants referred to the absence of an ethics committee or the presence of an ethics committee that was ineffective in addressing ethical issues. Five participants referred to the lack of ethics resources that contributed to the development of moral distress. Participant NM2, who was responsible for two critical care units and a staff of a hundred nurses in a large university-affiliated hospital, is planning to leave the hospital because of moral distress related to budget allocations and staff shortages. In answer to the interview question, "How would you describe the ethical climate in your hospital?", this participant replied:

> I believe that that the hospital intends to behave ethically but … the people making day-to-day decisions have become unequivocal in their ability to understand what the nurses face. They have become …um…deluded which creates a situation that allows, I think, more poor decisions …um…that could be made differently and benefit the facility so much more… decisions that could potentially save hundreds of thousands of dollars. (NM2)

NM 15, who works in a busy community hospital, identified physicians' refusals to discuss ethical issues as a source of moral distress:

> I think the biggest part of moral distress that we have is in the ethics side of …um…Nursing. We do not have a strong ethics committee here in the hospital. So, when the staff asks for – like 'this should go to the ethics committee,' um, I find it difficult to push that up. Um, I find it distressing in the fact that we can't get people together who want to talk about issues that are concerning us as nurses. (NM15)

NM8, who works in a small community hospital, is an experienced NM and was recently hired into the current position. This participant referred to the lack of an ethics committee as a source of distress. During a hospital administrative reorganization, the ethics committee was dissolved and bioethics policies were developed. NM8 found the new system of addressing ethical issues difficult because there was no avenue for discussion. The participant reported that a patient care issue that previously would have gone to the ethics committee for consultation was left unreported by the staff RNs because they were reluctant to personally challenge the physician directing the patient's care. This NM reported:

> We developed policies to address getting bioethics consultations …those policies were a little weak ….because if you had a concern it was funneled …through the administrator on-call and ultimately, I think, to the CNO…people felt a little you know, embarrassed …or deterred by having to go to a higher-up … and I thought that might prompt people to do less…asking of assistance. And we haven't had many bioethics requests…so, it just didn't sit well with me. (NM8)

NM10 works in a large university-affiliated hospital and had left a previous job because of unresolved moral distress and stated difficulties with the current ethics committee in the hospital. The hospital is "a policy-driven institution." Staff RNs are reluctant to call their ethics committee because the committee is composed almost entirely of physicians. This NM stated,

> [the nurses] kind of hesitate to call the Committee because you have to first connect with the attending physician. The docs believe it's all about *them*. And you try to explain to them, 'No, nurses are calling the Ethics Committee for help reconciling for themselves, you know … to understand where we are with this… and to help them be able to be at the bedside and be engaged with the patient and family.' A number of times the physicians have not been happy that we called the Ethics Committee and so the Nurses are kind of gun shy…. The ethical climate is totally again at odds with what we're faced with. (NM10)

NM15, who works in a small community hospital, reported resistance in attempting to develop an ethics consulting service for the unit(s) to help resolve ethical issues related to medically futile care:

> Oh, when I've talked to the Director of the Ethics Committee, he talks about law suits, law suits, law suits. You know, it's the – excuse my language- 'cover your

> ass' mentality. And, that you know, bringing it [the situation] to the ethics committee – oh, you know, you gotta cover yourself and da-de-de-da. It goes on and on. All they talk about is um, the legalities of it, not about the patient side. And, I don't understand that piece. (NM15)

In one disconfirming case, NM4, with many years of experience in a university-affiliated hospital, relied on both written bioethics policies and ad hoc ethics consultations with a physician ethicist. A nurse ethicist was not available, and NM4 indicated that nursing ethics issues were resolved through their own guidance as the NM, the physician ethicist, and written hospital policies:

> I have my own values and beliefs in ethical issues, I believe that that is supported by [direct supervisor] and I also feel that the Nursing staff seek out my values and beliefs to look at ethical situations on the Unit. In the event there is an ... ethical 'event' – however we want to define that … I openly have discussions with the Nursing staff and guide them in directions to look at where their resources are … following evidenced-based practice through our policies and procedures… I consider myself an expert in this field. I have been here for [many] years…[regarding a specific situation of medically futile care] … we did bring in a physician ethical group to debrief with the nursing staff, talk about their feelings and talk about their decisions to…not be involved in [the patient's] care…I felt this was a very good outcome. (NM4)

Moral Incongruity With Staff Nurses

The participants in this study spoke about an incongruity between their own moral commitment to Nursing and that of some staff nurses. The incongruity between professional and personal commitment became, over time, a source of moral distress for some NMs. NM6, who had recently created a new subspecialty ICU in a university-affiliated hospital, hired staff RNs from the university who had excellent academic records. However, this NM said the most difficult part of his or her job was "dealing with young women in their 20s who think they want to be nurses 'cause they see it on TV – until they see they have to work weekends, holidays ….sometimes they act like this is a big sorority" (NM6).

NM17 also spoke directly about intergenerational issues among nurses as a source of moral incongruity: "I don't think that nurses coming out of training right now are prepared for the reality of being a bedside nurse. …there are night shifts that need to be covered, there are holidays …a nurse asked me if [she or he] really had to touch the

patient!" This participant spoke about a trend among newer graduates to see the staff nurse position as a path to becoming a nurse practitioner or nurse anesthetist: "…a lot of people [nurses] come through [the ICU] in order to advance their career. … There is not the same mentality that I grew up with – since I've become a nurse, it isn't always there now" (NM17).

Employing incompetent staff nurses was a source of significant moral distress to many study participants. NM14, who works at a large suburban hospital, described the moral distress of having to gather a preset number of documented actions of a staff nurse "who's just not making it … in this environment" in order to move the nurse to another Unit (NM14). The NMs spoke about the time and energy invested in staff nurses who should not work in critical care areas.

Moral Incongruity With Physician Behavior

Issues related to physician behavior were identified in the data as a source of moral distress among the NMs. NM17 commented that besides having to work night shift, poor nurse-physician relationships was the most common reason nurses left the Unit. Evidence of moral incongruity was experienced in how physicians spoke to staff nurses, communicated with patients and families, and passive refusal to obtain legal consent from patients prior to medical procedures. Moral incongruity arose between how the NMs perceived the physicians ought to act as written in hospital mission statements and core values with the behavior some physicians displayed. Moral incongruity was evident in the lack of accountability the hospital administration expected from the physicians whose behaviors were reported. The lack of accountability was apparent to these NMs by a lack of response from senior hospital administrators or changes in physician behavior. The NMs described the negative impact this has on Unit morale and the effect of the disrespect on individual staff nurses. NM12 commented that physician verbal aggression was the second most common reason staff RNs stated for leaving their positions.

NM15, who works in a small community hospital, described multiple attempts to convince physicians to participate in ethics rounds:

> The doctors are …pooh-poohing us or shoo-shooing us away …they don't want to deal with it. We want to know how to prevent this [situation] from happening again. How can we get the patients what they need? And the staff what they need? They [physicians] just want to be done with it. (NM15)

Following a lack of response from senior hospital administrators regarding reports of physicians persistently shouting at nursing staff, one NM explained:

> We don't find that acceptable. I don't think anybody finds it acceptable. I make my staff understand that we [hospital administration] will do everything to negotiate with the physicians to …express their concerns in a much more non-threatening quieter manner. (NM17)

NM11, who works in a university-affiliated hospital that was recently featured in the news regarding excellence of care, described similar physician behavior: "If my nurses behaved like that, they would be fired … we have a written policy about acceptable personal conduct and they [nurses] would be fired." This participant noted that he or she had written multiple letters to senior hospital administrators regarding physician behavior but had never received a response:

> There is this double standard …I think that historically that has been accepted practice to demonstrate this kind of behavior. So, sometimes it kind of feels like you're trying to change history … change something that's inbred in the whole medical system. (NM11)

NM10 reported resigning from a position in a large university affiliated hospital because of moral distress that resulted from the incongruity between the intrinsic and extrinsic moral values of the hospital. This NM said, "[the physician] … didn't have the same values and integrity that I did. And, I struggled with [the physician's] interactions with staff …with family. I did not believe [the physician] was truthful." Despite multiple letters to administrators, the physician's behavior did not change and the NM's letters were not acknowledged. The NM continued,

> I couldn't put my head around why they would keep [the physician] working … if I couldn't reconcile that, then I couldn't support the organization and the staff in a way that I needed to …my moral values wouldn't let me continue to participate in what was happening, so I left. (NM10)

NM12, who admitted to thinking about leaving a position because of multiple ethical issues building into moral distress, said that physicians passively leave the staff nurses to obtain legal consent for medical procedures. The hospital has a written policy that states physicians must obtain a signed consent, yet many physicians refuse to comply with the policy. This NM said, "that's my *daily* struggle … it crosses the line of morals and ethics to me.…" (NM12). Despite multiple calls to the hospital administrators, the practice of not obtaining consent has continued.

Disconfirming Cases

Of the 17 NMs, two did not experience moral incongruence in the hospital ethical climate. NM1 is new to management and works in a small community hospital, whereas NM4 has been in management for many years and works in a large university-affiliated hospital. NM1 replied to the invitation to discuss experiences of moral distress with the statement that he or she had never experienced moral distress. NM1 attributed the lack of moral distress to the following:

> We are a faith-based hospital. We live our mission … it trickles down from the administration … I have their (Nursing branch and Medical branch) Blackberry and I can email them and get a response back … I am assured that they are going to take care of it. (NM1)

NM1 described the CEO as a person with whom everyone is on a first-name basis. The CEO makes daily rounds to at least one unit in the hospital and knows all of the Nursing staff.

The second disconfirming case was NM4, who reported total reliance on written hospital policies to resolve any conflicts. NM4 has an ethics manual that guides the nurses step-by-step through ethical decision making; the ethics manual contains step-by-step strategies for the staff RNs to follow once they recognize an ethical dilemma. NM4 reported having no ethical or moral differences with the hospital organization or any of the written policies.

The second subtheme is presented in the following section. "Becoming morally distressed: It's such a balancing act," includes participants' descriptions of becoming morally distressed. This section provides evidence that the accumulation of multiple moral experiences coalesce into moral distress.

Sub-theme II: Becoming Morally Distressed:
It's Such a Balancing Act

Throughout the iterative process of data collection and analysis, evidence accumulated that demonstrated the participants were balancing many concomitant challenging issues within the ethical climate of the hospital. The title of the subtheme is a phrase that more than one participant exclaimed when prompted to answer how they managed multiple concomitant ethical situations and what events prompted moral distress.

NM14 has worked for several years in nursing management in a large university-affiliated hospital. This participant reflected on issues related to patient safety because of a staff shortage and dealing with incompetent staff nurses. For NM14, moral distress resulted from efforts to maintain patient safety while completing documentation of incompetent staff nurses. This participant spoke about efforts to not foster a "poisonous atmosphere" among the staff who were aware of incompetency issues among their colleagues and said, "It's such a balancing act," in reference to meeting the multiple commitments of ensuring patient safety and managing issues related to staff incompetency and the stress responses of the nursing staff (NM14).

The data suggested that the experience of becoming morally distressed emerged over time but did not erupt due to a single event. This sense of emerging moral distress related to balancing multiple responsibilities was further probed in subsequent interviews. NM17, who was new to management but had been a staff nurse in another hospital for almost 20 years, reported:

> I think that managers deal with the same ethical dilemmas that nursing does, but then they also take on the responsibility for their, um, the well-being of the staff.…I would say that that's probably been my moral dilemma as a manager is delegating tasks not only for what's best for the situation but for the staff involved. (NM17)

At the time of another interview, NM6 had just returned to his or her office following a distressing conversation with a physician whose on-going treatment decision for a particular patient conflicted with what he or she and the staff nurses felt was the appropriate and compassionate treatment. During the interview, the NM showed evidence of becoming morally distressed and stated that this was "just one thing" among many that needed attention that day (NM6).

Evidence for "becoming morally distressed" was constructed through the answers to the interview questions regarding NMs' experiences of being morally distressed. Further probing questions in subsequent interviews added other explanations. For instance, in one of the subsequent interviews, NM17 responded to the interview question by describing the difference in the moral distress the participant had experienced as a staff nurse and current experiences as an NM:

> …The thing I find hardest in my role is finding that balance between the needs of the organization and the needs of the staff. I think it's the management position - where I think higher up it's a little bit different because it becomes more about the organization. But, being in the Unit on a day-to-day basis and knowing the stress that [the] staff feels – but also feeling the stress of having to meet the expectations of the organization. (NM17)

In response to a question regarding how the moral distress NM2 experienced as an NM was different from that experienced by staff RNs, the participant responded,

> The nurse manager is experiencing not only his or her own distress, but at an even higher level than the staff nurse. . . because the nurse manager ultimately has full responsibility, 24/7 responsibility, for a given area. . . that anything that transpires in that area is a direct reflection on that manager. . . um, and that is reality. (NM2)

NM13, new to management, was surprised by the experience of moral distress. Until this interview, NM13 admitted not having thought about it as a way to describe frequently experienced feelings. In response to the researcher's question, "Do you think

that the moral distress that nurse managers feel and experience is different from what you experienced as a staff RN?" the participant responded,

> It is quite different, I think, from…floor nurses'…moral distress. I had not thought about that before, you know? . . . You're kind of – you know, you're in the middle, you're … the person that, you know, gets blamed, I guess … from upper management. But, you're also the person that gets the complaints from – from the staff members about whatever decisions have been made. So, you're in the middle, being pulled both ways. You want your staff to be happy, but you also have to have them, you know, management …happy. (NM13)

During the interview, participants were asked to describe the feelings associated with being morally distressed. Analysis of the responses from these NMs revealed strong feelings of frustration, guilt, and anger. The evidence suggests that once the NMs could no longer find the balance among their ethical and moral imperatives, moral distress emerged. Components of the ethical climate appeared to be responsible for "tipping the balance." Data from four participants are presented and analyzed in the following section to demonstrate this finding.

NM14 stated that the experience of moral distress had been developing over time in response to knowing that a staff member would have to be dismissed from the Unit. However, hospital policy, union regulations, and employee law required particular documentation of specific events. This process was described as unfairly consuming NM14's time and budget resources that could have been used for other obligations. In this instance, administrative requirements were taking precedent over the NM's professional ethical responsibilities.

> …it's frustrating to me, causes me [moral] distress, when I know that [staff member] will be dismissed and yet have to encourage, you know, that person and the people that are investing time and energy into [the nurse], trying, you know, to have [the nurse] be successful. And uh, so, it's trying to maintain a – a – the right attitude in this environment despite the fact that I just know that at some point it's just not going to work out and [the nurse] is not going to last. (NM14)

The second datum is from NM16 who works in a small community hospital in a different geographic region. This participant's moral experience similarly led to moral distress over a period of time and developed in response to a colleague's action that had

nothing to do with the source of the moral distress. The purpose of including this datum is to demonstrate that the NM's moral distress evolved over time.

> Sometimes as a manager we're under stress … moral distress – it is, I guess, it is moral distress …. Let me ask you a question … is guilt a moral distress? Um, I think that sometimes, we fall short of our personal mark. We fall short of our personal values. And, sometimes I felt pretty guilty about that. … one of our Nursing administrators who I'm very fond of … uh, she caught me uh, on a bad day and – made a decision I didn't agree with and I really let her have it. And, um, I felt really bad about that, that night. And, I did lose some sleep over that … you know, it's more a sense of guilt than anything else . . . it was a very challenging situation and it –and it culminated two weeks of frustration with a situation that really had little or nothing to do with her. She was just the person who made the last decision that sent me over the edge. (NM16)

The third quote represents the interview with NM17, who spoke about tenuous staff-to-patient ratios that were determined by a daily patient census. If there was a sudden increase in patients, or the illness acuity of patients suddenly increased, there would be an urgent need for more critical care nurses. Although staff nurses agreed to be on-call, this NM experienced moral distress as guilt because of the duress under which staff RNs were working.

> I felt …guilt because for some reason we couldn't have enough resources and somehow that feels like it's something – though I understand at the moment we can't always have staff immediately available. But, um …. Guilt at asking people to work in a situation that isn't optimal. (NM17)

The fourth quote represents data from NM12, who described moral distress related to the experience of physicians who passively resist obtaining informed consent prior to procedures but leave the task, without legal medical designation, to the staff RNs. Although this evidence was presented earlier in the context of physician behavior, the situation is re-presented here to demonstrate the feeling of moral distress. In this circumstance, NM12 indicated that the staff RNs frequently obtain legal consent for the physicians for fear of retribution if they refuse. The NM stated that the repeated behavior "… makes me feel kinda sick … it makes me *angry, mad,* because a lot of responsibilities are put on the nurses … more and more responsibility" (NM12).

In addition to being asked to describe their experience of moral distress, the participants were asked questions, along with probing questions, about the things that facilitated or impeded resolution of their moral distress. They were also asked to describe the ways in which moral distress affected their personal lives. The third sub-theme is the analysis of those questions.

Sub-theme III: Managing Moral Distress:

Learning to Let Go

The interview questions were developed from the perspective of exploring components of the ethical climate that would facilitate or impede resolution of moral distress. Analysis of the accumulating data showed that each NM employed individual strategies to consciously manage moral distress within the context of the hospital's ethical climate and their personal resources. During an interview, NM7 answered the question, "How does this [moral distress experience] affect your personal life?" by saying:

> I've learned over the years really to walk out of my job and leave it at my job. . . when I'm at my job it causes a lot of grief and anger. . . I've learned to let go. I finally learned to let go. . . there's times I've actually been physically ill from the stress of this job, but I've learned, um, I can't do that. So, I'm learning to let go. There are things I can control and things I can't control. (NM7)

Through the iterative process between data collection and data analysis, probing questions in subsequent interviews allowed a deeper investigation of this insight.

Evidence accumulated and enriched the finding that letting go of the feelings of moral distress was not a passive action but a strategy the participants developed or learned. Six patterns of strategically moving through moral distress toward a resolution were identified among the 15 NMs who experienced moral distress. The six patterns were taking a positive perspective, talking (or texting) with other NMs, considering hospital policies and rules, seeking ethics resources, relying on a positive relationship with a supervisor, talking it through with family members, distancing, and developing plans to

leave their position. The following section includes data to support the analysis of this finding.

Taking a Positive Perspective

For some NMs, the process of letting go of the struggle as a way to find balance came through personal insights and finding the positive perspective. A participant, new to nursing administration, said:

> I've learned to slow down and look at things and – and I've been grateful to have people who've been there and to allow me to do that. So, I think what I'm trying to pass on are some of the gifts that people have given to me over time. And it's helped me in life as well as, uh, you know, in my career. Um, I'm able to be a lot more um, you know, introspective and extraspective. I can – I can look at everything around me and … try to be more objective. (NM16)

Another NM, who directs a very busy ICU in a community hospital and whose moral distress was related to physicians who were yelling at staff nurses and were not obtaining proper informed consent prior to planned procedures, said:

> I'm getting better at it. I've been a nurse manager for, oh, 3 and a half years, probably. And in the beginning, um, I found myself keeping my mouth shut more, um, and in situations where, "Oh well, the doctor's not listening" and "Oh, I think I've – I've done everything I can," now, I find I'm just – I just don't shut up. (NM15)

NM6, whose responsibilities included forming a new specialty ICU in a university affiliated hospital, stated that younger staff nurses appeared not to demonstrate the professional commitment to patient care that was expected. This participant felt that patient care was suffering because of the perception that these nurses expressed a low regard for the work of nursing. While the staff had been initially hired based on their academic performance in highly regarded Nursing programs, the lack of dedication to their work became a source of moral distress to this participant because it appeared that patient care was suffering: "The staff nurses were acting as though the ICU was a substitute college sorority" (NM6).The substandard patient care was troubling this NM to the extent that consideration was given to resigning. However, using a positive attitude was a strategy used to reframe the morally distressing experience:

> There was a point that I thought, “maybe I don’t want to do this.” But, on the other hand, I look at something I built – and I built it all by myself. You know, I didn’t have any employees, even charge nurses … I have such a personal interest in it that I try to always remember that this is something that I’ve done and that makes me proud personally as well as professionally…I have to kind of tell myself that a lot. (NM6)

NM11 described how a positive attitude was developed:

> I think it’s[moral distress in response to inappropriate behavior by physicians] probably akin to much of same kinds of feelings that we go through with death and dying. Where, you know, the first– the few first times where I was young enough where I thought, “Oh, wow. That was really inappropriate but I guess even the doctors do that” up until – you know – and then to the next stage where I recognized it [chuckles] and realized, “hey, that really is inappropriate.” To the third step where um, I also realized that, “we’re the same age and I’m a grown up and how come they’re not?” [laughs] to actively trying to do something about it. And then, I think I’m at the point now where I, you know, just going to let it be and I will – I will intervene uh very quickly, I think if somebody does something really wrong. I’m at the point now where I think the doctors kind of know that I’m out there kind of laying watch for them. And I – and one of the, I guess, the things that’s helped me let it go a little bit is that I think through the grapevine, you know, word sort of got around and that maybe unknowingly – that I don’t know – but maybe some of them have considered that and are maybe trying to actively change their behavior. (NM11)

Seeking the Advice of NM Colleagues

Fifteen of 17 participants spoke about tightly knit groups of NMs in their hospitals with whom they could either phone or text for support or advice. Talking, e-mailing, or texting about issues was a commonly used moral distress management strategy. One participant described communicating with NM colleagues as a way to

> …sort of hash through it and, you know, understand that you’re on the right track and doing the right things and thinking about the right things and you know, you just have to take a little time and hang in there. (NM14)

A new nurse manager in a small community hospital answered a phone call during the study interview. Afterwards, the participant explained that a newly hired NM colleague was anxious about how to present a disagreement he or she had had with a recently instituted hospital policy. The participant explained that the NMs in the critical care areas were a tightly knit group who had an agreement that they would give support or advice whenever it was needed (NM16).

Use of Hospital Policies

Hospital policies were either a way to prevent moral distress from developing or a strategy to manage moral distress for some of the study participants. NM4, who has many years of experience in a university-affiliated hospital, reported heavy reliance on hospital policies as a common strategy to resolve all of the ethical issues that arise. This participant consciously sets aside his or her own values and beliefs to follow hospital policies since that will ensure that every situation and every person is treated equally (NM4). Once this strategy was identified in the data, subsequent interviews included probing questions regarding reliance on hospital policies as a strategy to prevent or manage moral distress. Subsequent analysis revealed confirming evidence. NM16 also used hospital policies but in a different way. This NM tried to bend the rules in an effort to restore moral balance:

> I think there are different ways to interpret the rules. I may not interpret the rules exactly the same as another manager would. I think that it's important though that everyone is treated the same, um, regardless of the rules that there are. So, if I'm going to bend the rule or – or interpret the rule a little more leniently for one person, I have to be willing to do it for all. (NM16)

Reliance on a Positive Relationship With a Supervisor

All 17 participants in the study described a positive relationship with their direct supervisors. For the 15 participants who experienced moral distress, this relationship was a critical management strategy in the resolution of their moral distress. In addition to reporting that they had regular meetings with their supervisors, they also felt comfortable contacting them anytime by telephone, email, or texting. NM6 and NM9 reported that if it were not for the support and care of their supervisor, they would leave their position.

NM6 stated:

> . . . I also am very fortunate that my Director, the person I report to, is fabulous. She also is an MBA but she is a – has been a wonderful um mentor to me…and um when I've made mistakes has been very patient and um, I 've learned a lot from her. And, you know, I'm very fortunate to have that. . . you know, when she knows I've had a bad day or had to do something very difficult, she's been right there beside me or has called me at home at night to see if everything's ok. She's

> advised me um but doesn't get in the way. . . She's just a really very great mentor. I mean, I'm very lucky to have her. (NM6)

According to NM9:

> . . . we have a very supportive, um- Nursing - and strong Nursing leadership presence here who will back the Nurses up. And, but [direct supervisor] also is somebody that I can go to again, for advice. You know, she's been my boss – she's . . . been in management for many years. So, I feel – I feel like I can go to her and be honest with her and talk to her about my frustrations and she can tell me maybe how I can resolve those. …or give me advice as how to resolve those issues. (NM9)

A strong relationship with their direct supervisors was similarly described by the two study participants who did not experience moral distress. NM4, who relied on written hospital policies as a guideline to making ethical decisions, reported:

> If I have a situation, I …can electronically send a message to [director's name] or page her to let her know that I have an immediate request or concern… I've learned to work with her… She's a pretty – pretty straight shooter and those are the kind of people I like. (NM4)

NM1, who also had not experienced moral distress, reported that although situations were occasionally frustrating, there was immediate access to other people in hospital management, and the hospital culture revolved around immediate resolution of problems (NM1).

Talking it Through With Family

Talking with family members was another moral distress management strategy used by several participants. Three participants relied on their life partner, in particular, as a strategy to let go. NM13, who was new to nursing administration and to the employing hospital and was experiencing issues related to a nursing staff shortage, said:

> …my [life partner] has gotten good at, you know, listening to me like when I've had a really bad day. …I can dump out what kind of bad stuff that happened – the distressing things. And, [they've] gotten really good at just listening and not trying to problem solve….(NM13)

NM12, whose moral distress was related to staff shortage and float nurses who were practicing beyond their scope of practice, described using humor as a strategy at home:

> My [life partner] and I – we have a room in the house that is – a management, a nurse management room. I have like 30 minutes to talk about my job and then it has to be gone and there is no more discussion. (NM12)

NM17, who also struggled with a nursing shortage, was more reflective. In response to a prompting question, "Does this [moral distress] get into your personal life?" there were 12 seconds of silence before the verbal response was very softly spoken: "Well, I guess you would have to ask my [life partner]." This was followed by several seconds of silence before another verbal reply, "[life partner] would tell you it does." This participant stated that seeking family support was a large part of the strategy used to manage moral distress and a part of learning to let it go (NM17).

Making Plans to Resign

Five of 15 NMs who experienced moral distress spoke about resigning from a position as a strategy to manage their moral distress. Letting go for these 5 NMs meant letting go of, or resigning from, an NM position. Two participants reported leaving previous positions because of moral distress, but they are positive about their current positions despite feelings of moral distress. However, the insights of 5 participants who were thinking about leaving their positions are important.

NM7, with many years of management experience, expressed long-standing anger with hospital policies regarding staff discipline. NM7 felt that not only was a department outside of Nursing deciding discipline policies for Nursing, but that the actions were excessively punitive and did not allow for forgiveness, which was an important personal value. This participant described struggling for almost a year and recently deciding to resign because a balance could not be struck:

> It is morally distressing for me to the point that I'm going to resign in [gives a date]. I've given myself plenty of notice and I've told my management that. I've told them that I cannot work on this ethical level. I have struggled with this ethically. I have been a manager now for [sighs] 12 years. But I cannot do it. And, I have been very, very supportive of the cultural changes that we are trying to make in this organization. (NM7)

NM14, who works in a large suburban hospital, was considering resigning after many years in the position:

> I think the – the main part of it is [the morally distressing situation] that just recognizing that it's, you know, it's just part of the role – and I think the fact that it bothers me and the fact that, you know, it spurs me to – to continue advocating and doing something about it is a good thing. And then the day that it doesn't anymore is when I should really be worried. (NM14)

NM15 reported having thoughts "weekly" about leaving the position. When asked if that was meant seriously, the participant answered, "Sometimes…. Absolutely … I mean, sometimes I'm just frustrated and other times I'm serious" (NM15).

Knowing that letting go meant that the best resolution to moral distress was leaving their position was not an elusive concept to these participants. In answering a question about how to reconcile personal values that conflicted with hospital policies, NM 12 answered, with a sigh:

> One of the key things to – is to be a leader and –and be here, as such, is – or – or anywhere, I would say, actually is – is having, you know, your disagreement and your dissent among –among your team. And, then, you know, when you walk out of the room – you walk – and you decide and, uh, – if you find yourself not being able to … at some point … can't get behind it anymore, you know, that's – that's a clue. (NM12)

NM14, from a large community hospital, described moral distress related to physician behavior. This participant spoke about knowing when leaving the position would be the best way to let go of the moral distress:

> …if it impedes in my family life. If I couldn't separate work from home because I have a young family … and if I felt that I couldn't fight anymore. If I was done fighting for what was right – because every day you are fighting for what's right in this role. (NM14)

Conclusion

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. Seventeen NMs participated in single audio-taped interviews.

There were three basic findings in this study. First, the ethical climate is relevant to the moral experience of the NMs who participated in this study. It was through components of the ethical climate that evidence of the NMs' experience of moral distress emerged. This cohort of NMs perceived elements of the ethical climate as strongly influencing their experience of moral distress. When the implicit and explicit values expressed by the hospital were incongruent with the participants' personal moral values and professional ethics, moral distress emerged. The moral and ethical incongruities that led to moral distress included negative interactions with hospital administrators enacting policies they disagreed with, issues related to staff nurses, and poor behavior by physicians.

The second finding in this study was that moral distress developed over time. It did not erupt in response to a single event but was a response to multiple coalescing issues. The patterns of instances that resulted in moral distress identified in the data were components of the ethical climate as previously described. Moral distress was experienced as feelings of building anger, frustration, and guilt.

The third finding in this study was that NMs appeared cognizant of the moral dimension of their work. Analysis of the data showed that these NMs incorporated several strategies to manage moral distress and were actively engaged in resolving the issues leading to moral distress in addition to managing their response. However, the data showed that they were not willing to compromise their physical or mental health in order to endure moral distress. Among this cohort of 15 NMs who reported experiencing moral distress, three had current plans to resign from their positions because of moral distress and two had resigned from previous NM positions because of moral distress.

In conclusion, moral distress is an important practice issue for this group of NMs. Data analysis revealed the patterns of issues within the ethical climate of the hospital that contributed to the development of moral distress. Evidence indicated that NMs were aware of the consequences of moral distress to themselves and to patient care. Finally,

there is evidence that among the strategies NMs used to manage their moral distress were institutional practices, including the positive relationship with supervisors and ethics resources in the hospital (such as the ethics committee or nurse ethicists). Among this group of NMs, the data show that if they were unable to work through or transcend those issues contributing to moral distress, they were willing to consider resigning from the position.

Chapter V, the Discussion, will present the findings of this study in the context of pre-existing literature and demonstrate how the findings in this study contribute to the body of knowledge about the moral domain of Nurse Managers' practice.

Figure IV.1. Study Recruitment Results

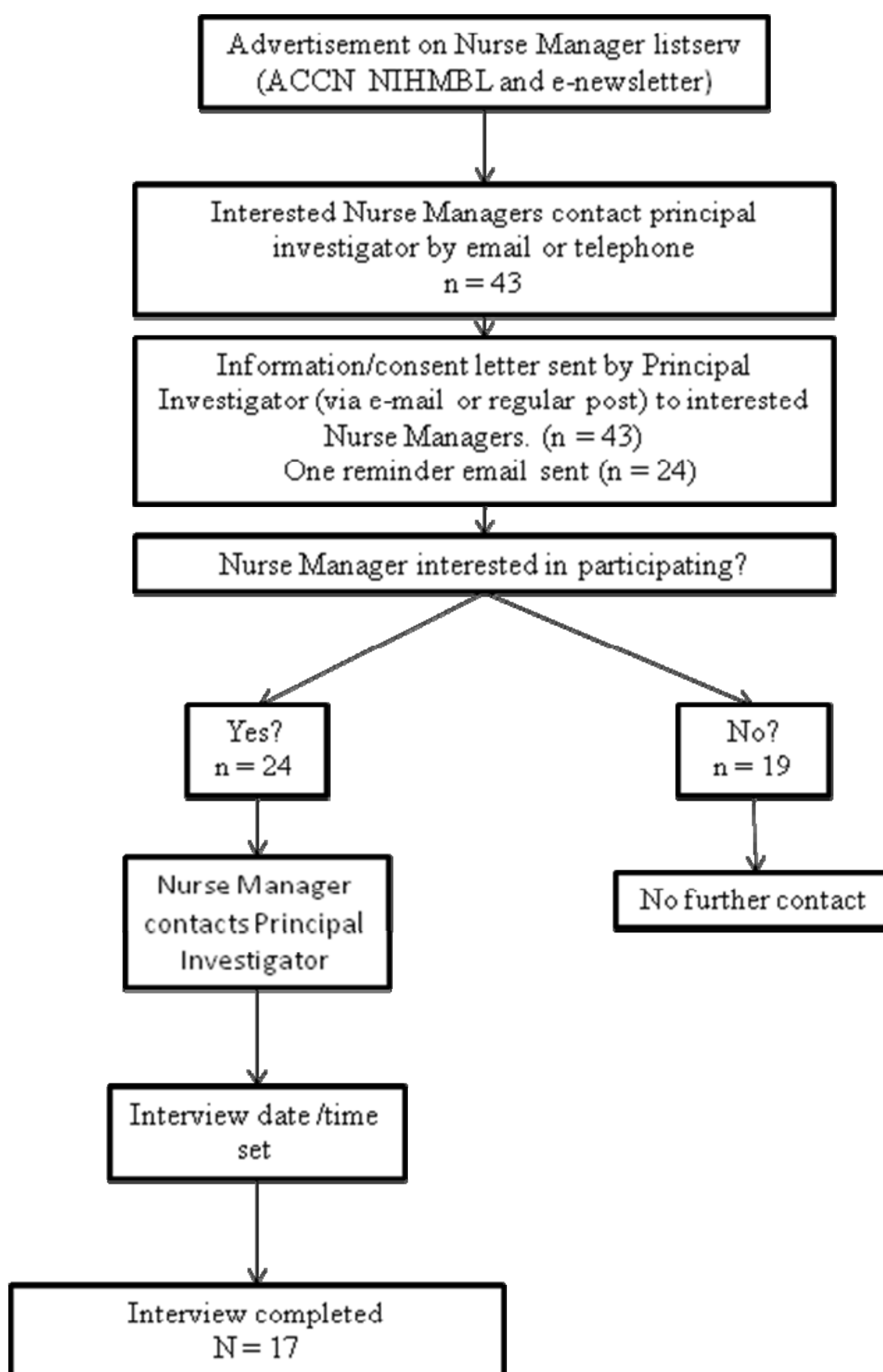


Table IV.1. Demographic Characteristics of Respondents (N=17)

Age			Gender		Race			Highest Academic Degree			Religiously Observant	
Mean	Range	SD	Female	Male	African-American	Caucasian	Hispanic	AD	BScN	Master's	Yes	No
46.4	31-56	± 9.0	15	2	1	15	1	2	5	10	10	7

SD = Standard Deviation. AD = Associate Degree. BScN = Baccalaureate Degree in Nursing. Masters = Master's Degree (includes Master of Science in Nursing, Master's Degree in Business Administration, Master of Arts Degree).

Table IV.2. Characteristics of Acute Care Hospitals (N=17)

Hospital	#beds	Rel. Affiliation	University Affiliation	Population Density			Geographic Location		
				Rural	Urban	Comm	West Coast	Mid-USA	East Coast
1	260	●				●	●		
2	900		●		●				●
3	150					●	●		
4	650		●		●			●	
5	110			●				●	
6	303		●			●		●	
7	100					●			●
8	81			●			●		
9	562	●				●	●		
10	250		●		●		●		
11	770		●		●			●	
12	200					●			●
13	150					●		●	
14	390	●	●		●				●
15	200					●			●
16	108	●				●			●
17	500					●		●	
Total #		4	6	2	5	10	5	6	6
Average	334								
SD	253								
Range	81-900								

#beds = number of beds in hospital. Rel. Affiliation = hospital that is formally affiliated with a religious organization.
SD = Standard Deviation. Comm = Community. Geographic location: West Coast = States that border on the Pacific Ocean; Mid-USA = States that do not border coastal waters; East Coast = States that border on the Atlantic Ocean.
● = positive response.

Table IV.3. Nurse Manager Administrative Characteristics (N = 17 Nurse Managers)

NM	T - employed by hospital	T- in current position	Total T as NM	#units	# of Staff	# of RNs	# of non-RNs
Avg	13.41	4.94	6.64	1.9	74.29	57.59	16.82
SD	11.09	4.03	4.66	0.94	48.10	49.83	9.72
Range	1-36	1-14	1.5-15	1-4	25-227	8-227	0-30

T = Time expressed in years. NM = Nurse Manager. #Units = number of units for which NM has responsibility. # of Staff = total number of staff who report to NM. # of RNs = total number of Registered Nurses who report to the NM. # of Non-RNs = total number of non-Registered Nurse staff who report to the NM

Table IV.4. Description of Issues that Nurse Managers Used to Illustrate Experience of Moral Distress Aligned with Hospital Characteristics

	Staff nurse attitude	Staff illness	Insufficient # of nurses	Hospital policies	Budget issues	Futile treatment	Physician behaviors
University affiliated hospital (n = 6)	●	●	●●●	●●●	●	●	●●●●
Religious affiliated hospital (n = 4)		●●	●●	●	●		●
Community hospital (n = 10)	●●	●●●	●●●●●	●●	●●●	●●	●●●●
Rural hospital (n = 2)			●	●●	●		●
Urban hospital (n = 5)		●	●	●	●	●	●●●

CHAPTER V

DISCUSSION

Introduction

The purpose of this qualitative interpretive description study was to examine Nurse Manager's perceptions of the external constraints on their moral agency, specifically the hospital ethical climate, which may contribute to their experience of moral distress, and to analyze how attributes of the ethical climate facilitate or impede resolution of moral distress. Previous research has shown that moral distress is a significant practice issue among RNs; more recent research has suggested an association between RNs' perception of the ethical climate and their experience of moral distress. Although NMs are strategically positioned in the hospital as the pivotal link between staff RNs and hospital administration, in addition to patient care responsibilities for staff satisfaction on their unit(s), little research exists regarding only NMs' experience of moral distress or their perception of the ethical climate of the hospital. The intention of this research was to narrow this knowledge gap in the literature by fulfilling three specific aims. These aims were to:

1. Assess patterns of instances, perceived consequences to patient care, or personal well-being that Nurse Managers find morally distressing.
2. Assess Nurse Manager's perceptions of the ethical climate.
3. Examine Nurse Manager's perceptions of how institutional practices or attitudes facilitate or impede resolution of moral distress.

Findings from the study were presented in Chapter IV. In this final Chapter, a brief overview of the findings is presented, followed by a discussion of the findings in the context of moral distress models and previous NM moral distress research, the study limitations, and implications for clinical practice, future research, and policy.

Overview of Findings

The study findings were organized into a core theme and two sub-themes. The core theme, Nurse Managers' moral experience, represents the participants' views of their jobs, personal moral obligations to their work (including patients, staff, and the hospital as an organization), and their perceptions of how the ethical climate of the hospital influenced their ability to fulfill their personally defined obligations to their work.

The first sub-theme, Experiencing Moral Distress Through Moral Incongruity, described the process through which their experience of moral distress developed in the context of the ethical climate of the institution. For the NMs in this study, moral incongruity arose when their expectations of how situations ought to be handled conflicted with their hospital's enacted values. Unresolved moral incongruities led to moral distress. The sources of moral incongruities that led to moral distress included disagreement with some administrative policies, negative issues related to staff nurses, and poor behavior by physicians.

The second sub-theme, Becoming Morally Distressed: It's Such a Balancing Act, described how participants balanced multiple, concomitant complex ethical situations. The data that clustered around this theme indicated that moral distress did not erupt in one single event but rather evolved over time.

The third sub-theme, Managing Moral Distress: Learning to Let Go, described the ways in which the NMs managed their experience of moral distress in order to maintain focus on their work and maintain their own well-being. The data that clustered around this sub-theme were organized into six different strategies that participants described in managing their moral distress response.

Discussion of the Findings

There are several findings in this study that confirm findings of other studies regarding NMs' experience of moral distress and perceptions of ethical climate; however,

there are key differences that are subsequently discussed. While there is a wide body of literature related to moral distress in Nursing, and a growing body of literature related to staff RN experiences of moral distress in the context of the ethical climate of the hospital, the body of published literature is narrow regarding NMs' moral distress experience within the ethical climate of the hospital.

A qualitative study of 15 NMs in one Canadian province found that NMs had ethical conflicts with their organizations that led to moral distress (Beaton & Gaudine, 2002). Similar to the participants in this study, the sources of moral distress for the Canadian NMs developed in response to having to enact policies with which they disagreed, including budget restrictions that negatively impacted staff-to-patient ratios, staff continuing education, and consequently morale on the Units. This outcome suggests that changes in Unit morale may lead to moral distress. Other similar issues between the present study and the Canadian study were disagreements with enforcing organizational policies related to staff discipline, centralized decision-making that influenced floating policies, and a lack of ethical resources accessible to the nurses within the hospital.

However, a second study of NMs, also using a qualitative design, focused on the increasing complexities of the NM role in acute care hospitals through an examination of their decision-making processes and ways of coping with stressful situations (Shirey et al., 2008). Rather than situate the NMs' decision-making processes and distress responses within the ethical domain of practice, the researchers included moral distress as one source of psychological stress related to the conflicts the NMs felt regarding the consequences of hospital administration budgets and financial decisions. No further consideration was given to NMs' experience of moral distress as a consequence of role complexities or increased stress. Rather, emphasis was placed on the experience of stress as a psychological emotion. Dismissing or under-estimating the experience of moral distress contributes to the lack of awareness of the ethical dimension of practice, does not

increase the recognition of ethically challenging situations (Epstein & Hamric, 2009), and thus does not emphasize the importance of ethical decision-making in everyday practice.

The findings in this study underscore the relevance of moral distress to the work of NMs and substantiates previous research by Shirey et al., 2008. The participants in this study described their sense that core personal values and professional ethics were being challenged, and sometimes violated, through their descriptions of the moral incongruities they experienced within the ethical climate of their hospitals. While there is an emotional/psychological component in the participants' descriptions of moral distress, the decision to place the issues within the ethical domain of practice is an important decision since personal moral values and professional ethical obligations were compromised (Epstein & Hamric, 2009). Further, placement into the ethical domain of practice strengthens the importance of identifying moral distress within the clinical milieu.

Three theoretical frameworks informed this study: two moral distress models, (Jameton, 1993; Wilkinson, 1987/88) and one ethical climate model (Victor & Cullen, 1987b). Jameton (1993) argued that nurses experience moral distress when factors external to the nurse, such as co-workers, institutional policies (including the social culture of the institution), or the nurse's internal factors, such as shyness, self-doubt, and lack of insight, block the nurse's moral judgment and thus render the nurse powerless to take the right moral action in a situation. According to Jameton's thesis, moral distress has two phases, initial moral distress and reactive moral distress. The first phase, initial moral distress, is the distress that happens "in the moment." That is, a nurse recognizes that personal core values have been violated and experiences the initial response, such as feelings of anger and frustration. Although there are many manifestations of the experience of moral distress, it is most commonly associated with feelings of anger, guilt, frustration, and withdrawal related to dealing with conflicting values with colleagues or institutional policies that thwart the nurse's moral judgment (Elpern et al., 2005; Wilkinson, 1987/88). The second phase of moral distress described by Jameton (1991),

reactive distress, occurs when the nurse continues to defer the right moral action and thus continues to experience moral distress. Wilkinson (1987/88) proposed that nurses who experience either initial or reactive moral distress develop psychological and spiritual disequilibrium in a manner that was labeled "disrupted wholeness." The disrupted wholeness has physical, emotional, and spiritual dimensions which, in part, result in withdrawing from patients and psychological disequilibrium (Wilkinson, 1987/88).

The findings in this study confirm portions of both Jameton's (1993) and Wilkinson's (1987/88) models. With respect to Jameton's (1993) model of moral distress, the participants demonstrated initial moral distress. That is, several NMs identified feelings of guilt, frustration, and anger during situations they described as morally distressing. The situations that led to initial (or acute) moral distress were identified through the pattern of "moral incongruities" with having to enact administrative policies with which they disagreed, issues related to staff RN incompetency (e.g., having to take time to work with the particular staff member to ensure patient safety which meant a delay in attending to concomitant responsibilities) and poor behavior by physicians (e.g., arguing with physicians to return to the Unit to obtain informed consent from patients, or consoling staff RNs who had been verbally abused by a physician).

This investigator's intention of using Jameton's (1993) model was to extend Jameton's (1993) argument that for NMs to enact organizational policies with which they may disagree, they may need to suspend their own moral agency with the consequence of experiencing moral distress that could linger over time. However, the evidence in the data did not reveal that this group of NMs had this experience. That is, there is evidence of initial moral distress but not reactive moral distress. The data raise the question that there may be some factor, not identified in these data, in the social structure of the organization that supports role differences between NMs and staff RNs such that there is a difference in the moral distress experienced by staff RNs and by NMs.

Published research literature renamed Jameton's term, reactive moral distress, as "moral residue." In defining the term, Webster and Baylis (2002) wrote 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), but it may also encourage later personal reflection. Other researchers have commented on moral residue as losing one's moral identity in a way that is both lasting and powerful (Epstein & Hamric, 2009) and as associated with depression, anxiety, avoiding patients, and burnout among staff RNs (Elpern et al., 2005; Gutierrez, 2005; Wilkinson, 1988). In the present study, strong evidence of moral residue was not identified. The NMs in the present study indicated that they knew the actions needed to resolve situations that led to moral distress; they did not defer moral action, nor did they identify feelings of powerlessness. Instead, this cohort described strategies to resolve their moral distress and to manage the situations so that patient safety and care and staff competencies were maintained. However, moral residue has been described as difficult to characterize (Epstein & Hamric, 2009), and this study did not specifically search for evidence of moral residue.

The framework for this study was also influenced by Wilkinson's (1987/1988) landmark study of staff RNs who experienced moral distress. In the model, Wilkinson suggested that moral distress was a process that unfolded from different moral distress indicators (kinds of situations, frequency of moral distress, authoritative constraints, such as from a nurse manager or nurse administrator, or feeling pressured to comply with physicians' patient care orders) and the nurse's own sense of wholeness. Wilkinson (1987/1988) postulated that the process of moral distress culminated in an erosion of an individual's sense of wholeness through feelings of guilt, anger and frustration to the extent that patient care was negatively affected.

The findings in this study are supported by Wilkinson's (1987/88) notion that moral distress does not erupt but rather evolves over time. Wilkinson noted seven moral

distress indicators within the development of the moral distress response: kinds of cases, frequency of distress, contextual constraints (such as disagreeing with medical treatment, disagreements with nursing administrators), feelings, nurse's sense of wholeness (psychological, spiritual, and physical health), effect on patient care, and coping behaviors. The participants in this present study spoke about balancing multiple obligations every day. The data indicated that when the participants developed a sense of moral incongruity, it arose over time and rarely erupted due to a single ethical event. Data analysis showed that conflicts between the NMs' own sense of moral obligation, professional obligations, and the expectations of the hospital organization arose as they reflected on the situation. These findings are similar to the indicators Wilkinson noted as contributing to the development of moral distress in staff nurses. However, the external constraints that led to moral distress among the NMs in this study included different kinds of authoritative constraints, such as enacting policies they disagreed with or dealing with poor behavior from physicians. The participants in this study did not appear to have an eroded sense of wholeness that Wilkinson described in her model. Although some participants described feelings of guilt, anger, and frustration, the data did not suggest an eroded wholeness as defined by Wilkinson (1987/1988).

Nurse Managers' Experience of Moral Distress in the Context of the Ethical Climate

The definition of ethical climate that guided this research was, "the shared perceptions of what is ethically correct behavior and how ethical issues should be handled," (Victor & Cullen, 1987b, p. 51-52). This present study explored NMs' perceptions of the prevailing ethical climate in their employing hospital in the context of how they experienced moral distress and how they resolved moral distress. Although the purpose of the exploratory nature of the study design is not to establish conceptual linkages, an interpretation of the data in this study suggested that the study participants were best able to fulfill their professional ethical responsibilities and their personal moral

obligations in an ethically positive climate. That is, when components of the ethical climate were not congruent with their professional and ethical personal moral values, the participants reported being morally distressed. The data in the study pertaining to ethical climate and moral distress clustered around three sources: administrative policies with which they disagreed, concerns about nursing staff, and difficult interactions with physicians.

Strategies to Manage Moral Distress

Nurse Managers in this study did not use the word "powerless" to describe their experience of moral distress. Previous research of moral distress frequently described the moral distress experience in terms of staff RNs feeling powerless within the complex institutional infrastructure (Pauly et al., 2009; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Wilkinson, 1987/88). In other studies of NMs' experience of moral distress or psychological distress, the NMs were similarly reported to feel powerless to change elements within their hospital ethical climate (Gaudine & Beaton, 2002; Shirey, 2008). The participants in this study were clearly experiencing moral distress and described their feelings as anger, frustration, guilt, and sadness in response to morally troubling situations. Yet, they demonstrated good insight into their organizations and were adept at developing strategies to manage their moral distress. This finding is supported by the findings in another study of NM stress and coping experiences (Shirey et al., 2010). In that particular study, the NMs were similarly described as "acute systems thinkers" who demonstrated keen insight into the organization and in developing coping strategies (Shirey et al., 2010).

Similar to findings in the study of NM role stress and organizational culture by Shirey et al. (2010), the evidence in this study supported the finding that the participants developed and used strategies to manage their moral distress and worked within the constraints of their institutions to resolve issues that were causing moral distress. The management strategies of the participants in this study clustered around a theme of

"letting go." The metaphor of letting go described a hierarchical strategy employed by the participants who describing methods that ranged from letting go of the distress (taking a positive perspective, seeking the advice of colleagues), to verifying actions with a supervisor (reliance on a positive relationship with a supervisor, talking it through with family members), to the final step in "letting go": making plans to resign from the position. The participants in this study did not appear to ignore the issues that led to moral distress; rather they acknowledged their distress and devised several strategies to deal with it in a way that preserved their personal moral integrity and professional core beliefs and values.

Previous research has discussed moral distress management strategies that clinical staff nurses have used (Penticuff & Walden, 2000; Raines, 2000), nurse managers have used in response to work-related stress and organizational culture (Shirey et al., 2010), and nurse administrators have used (Sietsema & Spradley, 1987) that are similar to the strategies used by the NMs in this study: support from colleagues, supervisors, and family members. Seeking support from ethics committees (when available to the participants) was also found in other studies (Penticuff & Walden, 2000; Raines, 2000). In targeting moral distress as a practice priority issue, the AACN developed a strategy to increase awareness and management of moral distress (AACN, 2005).

In a recently proposed model, the crescendo effect, researchers described three patterns of coping with moral residue: withdrawing from a situation, conscientious objection, or burnout and withdrawal from the profession (Epstein & Hamric, 2009). Data analysis in this present study suggests that there may be a crescendo effect in terms of repeated exposures to moral distress. However, the moral residue component of the model was not apparent in the data.

An important management strategy used by five participants in this study was to recognize the need to leave a position. Of the 15 NMs who reported feeling morally distressed, two NMs stated that they had previously left positions because of moral

distress, and three NMs indicated their plans to resign from current positions. Those who spoke about resigning due to moral distress described deep frustration particularly with having to enact policies they found deeply troubling. One NM was resigning because of a hospital policy of labeling employees who had demonstrated poor performance on one occasion with a persistent label that would limit the employees' movement within the organization. A second NM was resigning due to a floating policy in the hospital that they felt endangered patient safety and the hospital's refusal to discipline physicians who repeatedly exhibited disrespectful behavior towards staff RNs. Although this study has a small sample of NMs, the percentage who discussed leaving their jobs as a strategy to manage moral distress presents an important observation given the current nursing shortage and the anticipated shortage (Buerhaus et al., 2009). The healthcare work environment, including attributes of an ethical climate, have been implicated as a contributing cause of the nursing shortage (Institute of Medicine, 2004).

The moral distress management strategies employed by the participants in this study demonstrated resilience when confronted with ethical challenges in their work environment. They clearly described abilities and strategies to manage moral distress in order to maintain their professional and personal moral integrity within the ethical climate of hospital.

Study Limitations

Several issues limit the findings of this study. The limitations include issues of recruitment and design. Participants for this study were primarily recruited by convenience sampling through one on-line listserv for NMs and a membership electronic newsletter of the American Association of Critical Care Nurses, which limits generalizability. A pool of respondents was anticipated that was larger than the number who responded to the study advertisement. While the AACN estimated the NM listserv to have several hundred members, 43 NMs responded to the advertisement. Ultimately, the total number of NMs who participated in the study met the anticipated sample size.

The study advertisement specifically asked for participants who would be comfortable having an audio-taped conversation regarding morally distressing experiences. There may have been people who were not willing to have a conversation taped and transcribed despite reassurances in the study advertisement that identifying information would be protected. Since there was no mechanism in place to know why NMs declined to participate in this research, the characteristics of those who were not interested in participating could not be compared to those who did participate in the study. Little is known about the characteristics of NMs who choose to participate in research versus those who choose not to participate.

There was a wide distribution of hospital attributes in this sample which added to the richness of the data. The intention of the study was to have a sample size that would allow an exposure of hospital attributes in the data analysis. However, the small sample size did not allow this to be completed. If this study were to be replicated with a larger sample size, other attributes, such as Magnet or Beacon status or JCAHO compliance, could be included since other research has suggested that these variables might add to the richness of the data (Corley, 1998a; Hamric & Blackhall, 2007; Rice, 2008).

The limitations of the study related to design issues center on the narrow generalizability of the findings and the interview process. The design of this study does not permit inferences of cause and effect. Further, since this is a small qualitative study, the findings are limited to this group of respondents. However, the qualitative descriptive design does provide rich data for analysis such that an important construct (management strategies) surfaced and expanded a dimension of NM practice that warrants further exploration.

The interview process in this study had strengths and weaknesses. Since little is known about NMs' experiences of moral distress, the interview strategy of the study was justified. More than one interview with each participant would have provided richer data by allowing clarification of thoughts, time for the NMs to reflect on the moral dimension

of their work, and an opportunity to clarify findings with the participants. However, these NMs were very busy during their work days and the time needed even for one interview may have been an impediment to participation. As expected, participants were unable to anticipate the demands of their work day and on several occasions the interviews were interrupted by staff needing information, a patient crisis, or a newly scheduled meeting. Consequently, interviews were sometimes disrupted, which changed the course of the conversation.

Implications for Nursing Practice

Moral distress has been identified as an important practice issue among staff nurses (Austin, 2005; Corley, 2002; Hamric, 2000) and more recently, among NMs (Gaudine & Beaton, 2002; Shirey, 2008). Other recent studies have demonstrated the relevance of the ethical climate of the hospital as an important part of the work environment that influences not only staff satisfaction but patient safety and quality of care (Institute of Medicine, 2004; Pauly et al., 2009; C. Ulrich et al., 2007). The analysis for the present study indicated that this group of NMs similarly considers moral distress an important practice issue and that it occurs in the context of the ethical climate of the hospital.

Although the findings from this small qualitative study do not provide a substantive basis for changing clinical practice, the findings suggest a need to facilitate NMs' recognition of moral distress related to their particular role within the hospital and to explore other positive strategies to manage the response and address the cause. Other studies have proposed strategies for addressing moral distress (Austin, Lemermeyer, et al., 2005; Epstein & Hamric, 2009) and the American Association of Critical Care Nurses (AACN, 2005) developed the 4 A's approach to modifying moral distress. The finding from this study, that the respondents developed positive strategies to manage their moral distress, adds to the work of other researchers (Shirey et al., 2010; Skytt et al., 2007). This study has further implications for NMs in that they consider using existing

organizational resources (e.g., relationships with colleagues and supervisors, ethics consultations and ethics committees, counseling services) and personal resources (e.g., partner/family relationship, relaxation, exercise) in a manner that preserves their personal moral integrity.

Implications for Research

The results of this study highlight the need for future research focusing on NMs' experience of moral distress, their perceptions of the ethical climate in acute care hospitals, and strategies for managing moral distress. In particular, further study of this complex relationship should include a random controlled trial to look for factors that decrease moral distress.

First, future studies focusing on moral distress among NMs experience of moral distress in the context of the hospital ethical climate should include a larger sample. The design of this study provided insights into the phenomenon of moral distress and ethical climate among NMs and provided opportunities to gain newer understandings. However, this study was also limited in its size and scope. For example, only one research interview was conducted with each participant. Typically, interpretive description studies incorporate a minimum of two interviews with each participant. Because of this limitation, the insights generated are somewhat limited. Including a larger sample size would increase the variability in the sample and allow richer and more in-depth data collection and analysis of other variables as previously discussed. Extending interviews to some staff RNs and NM supervisors would enrich the understanding but also require a different study design. Increasing the understanding of the ethical domain of NM practice would provide important information on hospital organizational culture, including the ethical climate and the influence on patient safety, quality of care, staff health, and staff retention.

This research supports previous work that describes the complexities of the role of the NM and strategies that could support both individual and organizational factors

(Shirey et al., 2010). Given that the current nursing shortage is anticipated to worsen (Buerhaus et al., 2009), continued research that addresses work environment factors (IOM, 2004) and individual management strategies (Shirey et al., 2010) is essential among NMs in acute care hospitals.

The role of the NM is complex, yet relatively little is known about NMs' actual work demands (Shirey et al., 2010). There are few studies that specifically focus on ethical issues related to NM roles or their scope of practice. Future research could further delineate NM recognition of ethical issues and ethical decision-making processes, particularly in the context of the current economic crisis and escalating health care costs. Anticipated changes to health care delivery in United States will impact in-hospital care with direct consequences related to NMs' budget allocation decisions.

Integration of qualitative and quantitative findings could augment additional information about the process of developing moral distress and understanding the complexities of the ethical climate of the hospital. Quantitative studies have examined staff RNs' perceptions of the ethical climate of the hospital (Corley et al., 2005; McDaniel, 1997; Olson, 1998). These models have not been tested among NMs. The results of this study show that while NMs experience problems similar to those of RNs that lead to moral distress, their experience may not be completely understood with these models. Olson (1998) included a small sample of NMs within the larger RN sample in development of the Hospital Ethical Climate Survey. However, the sample size was too small to analyze the data separately. Future research should endeavor to integrate qualitative and quantitative data from NMs to improve our knowledge related to moral distress and ethical climate.

Other studies could examine successful strategies NMs use to access resources within the hospital infrastructure to resolve moral distress. One of the key moral distress management strategies participants used in this present study was to electronically communicate with their NM colleagues by emailing with a smart phone or computer.

Research was not located to suggest that this is a common strategy used by NMs. However, research has shown online knowledge networks foster efficient and effective communication within organizations and may be a way for leaders within the hospital to share solutions with colleagues (MacPhee, Suryaprakash, & Jackson, 2009). Future research could explore the use of electronic technology as an effective strategy for NMs to react to and more effectively manage situations as they arise.

Several participants in this study commented on either a lack of ethical resources or barriers encountered in accessing ethical resources in their hospital as a source of moral distress. Other participants spoke of their reliance on consultation with nurse ethicists and ethics rounds, conducted by nurses for the staff RNs as a way to help manage morally distressing clinical situations. Decisions to request an ethics consult may be a reflection of the social-moral culture of the hospital, and accessing ethics consultations can have professional consequences on nurses who make the request for the consultation (Gordon & Hamric, 2006). The participants in the study reported varying hospital policies with respect to who may request an ethical consultation and the procedures by which the request can be made. Future research should address inequities in policies and the impact of these policies on development of moral distress and resolution of moral distress among NMs.

Implications for Policy and Hospital Leadership

Adding to the implications for clinical practice and future research, the findings from this present study have implications for policy and hospital leadership. The findings from this study suggest that hospital leadership should investigate NMs' perceptions of the hospital ethical climate and the ways in which the ethical values of the organization are enacted at the level of each Unit.

Further, hospitals are morally obligated to understand the role complexities of their NMs, particularly related to situations that lead to moral distress, and to endeavor to work with staff to control those situations. Nurse Managers reported issues related to

poor physician behavior. Hospitals are morally and legally obligated to create and sustain healthy working environments. When unacceptable physician behavior is reported, there should be transparent strategies to effect behavioral changes.

A relevant finding in this study was that 5 of 15 NMs who experienced moral distress plan to resign from positions in hospitals that they describe as not responsive to resolving morally distressing situations. Although recent studies of job satisfaction and attrition have not explored moral distress, this study adds to early studies that demonstrated moral distress to be a causative factor for RNs' intention to leave a job (Hart, 2005; Corley et al., 2005) and NMs to consider leaving a job (Gaudine & Beaton, 2002; Shirey, 2008). In the present study, all of the NMs described a strong commitment to their work. And, as described, the data in this present study showed that the participants developed and used strategies to manage moral distress. However, one of their strategies was to recognize the boundaries of their well-being. When that boundary became blurred, the data suggested that resignation from their position was one moral distress management strategy.

The data in this study adds to previous research regarding nurse attrition. Previous research articulated several contributing workplace factors that contribute to nurse attrition. Among these reasons is dissatisfaction with the work environment (Auerbach et al., 2007; Buerhaus et al., 2007), including the ethical climate (Hart, 2005). This present study, although a small qualitative study of NMs, adds to the growing body of knowledge regarding the importance of a positive ethical climate. From a policy perspective, the findings in this study suggest that there may be benefit to administrative leadership communicating directly with NMs to learn about the issues that are leading to their moral distress and work with them to prevent job attrition. In addition to the administrative disruption to individual unit(s) that may place patient care at risk, there are the financial costs of replacing an NM.

Conclusions

This study provided an insight into the moral distress experience of a group of NMs from geographically distinct regions in the United States. The sources of moral incongruity that led to moral distress included disagreement with some administrative policies that NMs had to enact, issues related to staff RNs competency and attitudes, and poor behavior by physicians. The important finding in this study is that the participants did not describe feelings of powerlessness but employed six different strategies to manage their moral distress experience while working within the ethical climate of the hospital. For a majority of the participants, the strategies included taking a positive perspective, seeking the advice of NM colleagues, reliance on a positive relationship with a supervisor, and talking it through with family. For some of the NMs, their final strategy was to make plans to resign from their position. The findings from this study underscore the relevance of moral distress and the ethical climate to the practice of NMs.

APPENDIX A

DATABASE SEARCH STRATEGIES

Table A.1. Database Search for Relevant Literature Reviews

Electronic Database	**Keywords/Search Terms**	**Literature reviews found**	**Literature Review accepted**
Academic Search Elite	Moral Distress and “literature review”	3	1
	“ethical climate” AND “literature review”	3	1
	DE “NURSE Administrators” and “literature review”	4	2
	DE “NURSE Administrators” AND “literature review	4	1
	Ethical climate and literature review	3	1 (requested 09/25/09)
	DE “Nurse Administrators” and DE “Responsibility”	6	0
Cumulative Index to Nursing and Allied Health Literature	“Moral distress” AND “literature review”	6	Schluter, J., Winch, S., Holzhauser, K. and Henderson, A. (2008)
	(MH “Nurse Manager”) AND literature review OR (limiter) review	38	Schluter, J., Winch, S., Holzhauser, K. and Henderson, A. (2008)
	Ethical climate and literature review	36	None met criteria
	Moral distress and literature review	3	Schluter, J., Winch, S., Holzhauser, K. and Henderson, A. (2008)
PubMed	Ethical climate and literature review	42	Austin, W., Lemermeyer, G., Goldberg, L., Bergum, V., & Johnson M.S. (2005); Hanna (2004); McCarthy, J. & Deady, R. (2008); Schluter, J., Winch, S., Holzhauser, K. & Henderson, A. (2008)
	“Nursing, Supervisory” [MeSH] AND “Nurse’s Role” [MeSH] AND Review [Publication Type]	1	Schluter, J., Winch, S., Holzhauser, K. and Henderson, A. (2008)

Table A.2. PubMed Database Search Strategy and Results

Search #	Subject Query	Results	Papers Meeting Inclusion Criteria
1	“nurse administrator”[Mesh] OR “Nursing, Supervisory”[Mesh]	7424	Did not evaluate, narrowed search
2	“head nurse” OR “head nurses” OR “Nurse Manager” OR “Nurse Managers”	2243	Did not evaluate, narrowed search
3	“Ethics, Institutional”[Mesh] OR “organizational ethics” OR “ethical climate”	2,731	Did not evaluate, narrowed search
4	“Ethics, Institutional”[Mesh]	2699	Did not evaluate, narrowed search
5	“ethical climate”	33	
6	“Ethics, Institutional”[Mesh] AND #2 OR #1	7427	Did not evaluate, narrowed search
7	“moral distress”	147	Did not evaluate, narrowed search
8	#1 OR #2 AND #3	185	Did not evaluate, narrowed search
9	#5 AND #7	19	17

Table A.3. Cumulative Index of Allied Health Literature (CINAHL)

Search	Subject Query	Results	Papers meeting Inclusion Criteria
1	(MH “Nurse Managers+”) or (MH “Nursing Management”)	4598	Did not evaluate
2	“moral distress” (limiter = Research)	96	33
3	#1 AND #2	1	0
4	(MH “Ethics, Organizational”) or (MH “Ethics, Nursing”)	5,608	Did not evaluate
5	“ethical climate” (limiter = Research)	15	11
6	#2 AND #5	3	3
7	((MH “Ethics, Organizational”) or (MH “Ethics, Nursing”) or “ethical climate” or “moral distress” or “ethical distress” or “organizational ethics”) and (#2)	6	6
8	(MH “Ethics, Organizational”)	156	Did not evaluate
9	(MH “Ethics, Nursing”)	5,919	Did not evaluate
10	#7 AND #8	6	1
11	#7 AND #8 (limiter = Research)	1	1
12	#1 AND #5	1	0

Table A.4. Academic Search Elite Database

Search	Subject Query	Results	Papers meeting criteria
1	“moral distress” (no subject heading)	70	34
2	“ethical climate”	32	6
3	DE “NURSE Administrators”	1,159	Not reviewed
4	DE “RESPONSIBILITY”	1,832	Not reviewed
5	#3 AND #4	6	1
6	Ethical climate AND nurs* (Sub) scholarly journals limitation	2	2
7	Ethical climate AND nurs* (Sub)	12	5
8	#1 AND #3	0	
9	#2 AND #9	0	

APPENDIX B

EXEMPLARS OF MORAL DISTRESS

Exemplars of Moral Distress, *Well* Blog Entries, New York Times, February 9, 2009

"… It's easy to loose [*sic*] the energy and focus in the care of our patients when their [*sic*] are so many outside agendas competing for our attention. Voltaire said that the enemy of good is perfect. It is impossible to be a perfect agent for our patients, our employers, the payers, the legislators, the litigators, our teammates, our families all at the same time. Compromises are made daily, hourly, and minute to minute. It is common to find oneself trying to meet competing demands and loose [*sic*] sight of why we went into medicine in the first place. The relationships that we have with our patients and healthcare teammates as we navigate together wellness, illness and injury is why we do what we do."

"Today's post, and the post from the 4th [*sic* February 4, 2009] regarding nurse's [*sic*] who care too much, were dead on for me. I am feeling particularly burned out this week after a long weekend of nothing but working myself into a deep, dark, cold dead end. I mean, that is how it feels. You care about your patients. You want to do what is right. But then you are up against a system that does not care at all, MDs with attitude and other nurses who are clearly not competent, but a manager's delight. It is enough to make you want to run away and scream at the absurdity of it all. But then you realize that you have to take care of the patient. They are depending on you. You must do what is right. And so we do. We go on. We try not to compromise our values. It isn't easy. Many times we are forced to go along with a decision that haunts us. We have all had at least a few moral dilemmas that we will always carry with us. Most times they are more about prolonging someone's suffering than an error that caused someone harm.

I am not complaining, it is just the way it is and has been for the past 29 years that I have been an RN… It is just that it should not be this frustrating when you are only trying to do what everyone knows is right."

APPENDIX C

SAMPLE LETTER TO AMERICAN ASSOCIATION OF CRITICAL CARE NURSES

Date

Name of contact person
AACN Address

Dear (Name)

This letter and enclosed information is a follow-up to our telephone call (date) regarding my quest for study participants through the AACN members. I am a Registered Nurse and a doctoral student in the College of Nursing at the University of Iowa. This dissertation research is entitled, "Acute and Critical Care Nurse Managers' Experience of Moral Distress in the Context of the Hospital's Ethical Climate."

Prior to submission of this research proposal to the University of Iowa Institutional Review Board, I wish to establish a research relationship with the American Association of Critical Care Nurses. As we discussed in previous telephone conversations, I am recruiting Nurse Managers presently working in acute or critical care units to participate in a telephone interview. I would like to advertise the research project and the need for volunteers in the AACN on-line newsletter and in the AACN NIMBL LISTSERV. Advertising for volunteer participants will begin after IRB approval, likely late 2009. Data collection will begin as soon as participants contact me and will conclude once the sample numbers are reached. I expect the research to be completed by Spring 2010.

I look forward to further conversations with you and I anticipate mutually beneficial results from this research project. My contact information is listed below.

Thank you for your support of this project.

Sincerely,

Rebecca Porter, MSc, ARNP, BC
University of Iowa
College of Nursing
200 Newton Road
Iowa City, Iowa 52242

Home telephone: 319–354–3582
Cell telephone: 319–321–0938
E-mail: rebecca-b-porter@uiowa.edu

APPENDIX D

OVERVIEW OF RESEARCH PROPOSAL FOR AMERICAN ASSOCIATION OF CRITICAL CARE NURSES

"Acute and Critical Care Nurse Managers' Experiences of Moral Distress in the Context of the Hospital's Ethical Climate"

The impact of the current and pending global nursing shortage is well-documented. Within the next decade, the anticipated shortfall of registered nurses is expected to be twenty percent less than required to maintain the health of Americans. In the United States, there are presently two million licensed registered nurses, most of whom work in acute care hospitals. Of this cohort, almost ten percent work as Nurse Managers whose role is pivotal in managing units within their employing hospital. The work environment, including ethical aspects, has been identified by the Institute of Medicine as critical to sustaining a healthy workplace and the high quality of patient care. Previous research concerning nurses' experiences in morally distressing situations has indicated that some nurses have left their positions or left nursing entirely because of their distress or disillusionment with the ethical milieu of their workplace. Professional organizations have addressed the issue of moral distress in the nursing work environment. However, little is known about Nurse Managers' perceptions of the ethical environment of their employing hospital and how this perception conditions their ability to resolve morally distressing situations.

Study Purpose: to describe nurse managers' perceptions of their employing acute care hospital and their experiences of morally distressing situations in the context of their professional commitment to their hospital and the staff for whom they are responsible.

Study Design: Qualitative Interpretive Description

Study Method: semi-structured interviews, by telephone, to identify how nurse managers' perceive their ethical environment, to consider some circumstances of morally distressing situations, and how the ethical environment might conflict with the resolution of those morally distressing situations.

Study Sample: English-speaking, licensed Registered Nurses presently who are presently employed as Nurse Managers of a critical care or acute care unit in a hospital in United

States. Participants must be willing to have a telephone interview audio-taped. Anonymity of the participants will be guaranteed and no identifying characteristics will be used in any transcripts or reports generated by the research.

The information generated through this research project will provide an insight into the ethical milieu of acute care hospitals that has not previously been published in nursing literature. It will also provide insights through the eyes of nurse managers whose perspectives have not previously been considered separately from the larger cohort of licensed registered nurses in the moral distress literature. Understanding nurse manager perspectives and the contextual factors of the ethical environment of their employing hospitals is essential to the development and evaluation of programs that will generate ethically sound environments to promote healthy workplaces that in turn will improve the quality of patient care and associated outcomes.

Recruitment Procedure: The study will be advertised in the AACN online newsletter and AACN LISTSERV for nurse managers (NIMBL). Nurse Managers who are interested in participating in the study can contact the study investigator by telephone or by e-mail with a phone number at which they can be contacted. If the potential participant would like to participate in the study, a consent form and contact form indication permission to be contacted will be sent to the participant. The participant will contact the investigator to signify interest in the study. The investigator will further explain the study, including anonymity protection and review of the consent form. If the participant agrees to participate in the study, an interview date will be set. Oral consent to volunteer in the study will be established at the beginning of the taped-interview.

All forms and explanations will be provided in compliance with the University of Iowa Institutional Review Board to ensure participant protection during and after the research process. No recruitment will begin until written permission is obtained from The University of Iowa Institutional Review Board and the American Association of Critical Care Nurses.

Data Analysis: audio-tapes of the interviews will be transcribed and the narratives will undergo thematic analysis using established qualitative research methodology. Thematic analysis will allow compilation of the narratives, using direct quotes, to find and analyze patterns that describe the target phenomenon. Demographic data will be described in aggregate to characterize the participants.

Data Reporting: The doctoral dissertation will be the primary vehicle of reporting the results of this study. There may be research-based articles that are generated from the research. No study participants or employing hospitals will be identifiable. Demographic reports will be in aggregate only. No hospital names or specific geographic location will be identified in any reports. All of the original data will be destroyed in concordance with University of Iowa IRB regulations.

APPENDIX E

SCRIPT FOR INFORMING POTENTIAL PARTICIPANTS ABOUT STUDY

A doctoral nursing student at the University of Iowa is interested in conducting a study about Nurse Manager's experience with moral distress and the ethical climate of hospitals in United States. She would like to conduct telephone interviews with acute care and critical care Nurse Managers. Names of participants and hospitals will be kept strictly confidential. If you would like more information, please contact Rebecca Porter at (319-354-3582) or e-mail: rebecca-b-porter@uiowa.edu and an information letter that contains details of the study will be sent to you.

APPENDIX F

INFORMATION LETTER

Date

Inside address

Dear Potential Participant

Thank you for your interest in participating in this research study. The purpose of the study is to explore the perceptions Nurse Managers have of the ethical climate of their employing hospital during situations that they find morally distressing. Moral distress is the experience someone might have when they know the right course of action to take but are unable to carry it out. The ethical climate of a hospital is that part of the workplace environment in which moral decision-making takes place. Because moral distress is a relatively common experience, the ethical climate of the work place can help or hinder the resolution of moral distress. I am interested in discovering the experiences Nurse Managers have had or are having with these situations.

If you agree to be one of 15-30 study participants, I will ask you to participate in a telephone interview/conversation about your experiences of moral distress and your perception of the ethical climate of your hospital. The interview will take about one hour. There is the possibility that I will want to talk with you a second time to clarify some of your answers. All the interviews will be tape-recorded and I will transcribe the tapes. You do not have to answer all of the questions. If you think of more information you would like to share after the tape-recorder is turned off, the interviewer may record your thoughts by handwritten notes and include these in the data analysis.

All of the information you provide will be kept confidential. Because federal regulations and The University of Iowa Institutional Review Board may inspect and copy records from this research, we will take rigorous measures to maintain your privacy and total confidentiality. These are the steps we will take:

a. Your name, contact information, and hospital of employment will not be used in the study data. This information will be coded. Information linking you and your code will be hand-written and kept in one separate, locked location that is

accessible only by me or my Dissertation Advisor, Dr. Janet K. Williams. This information will be destroyed by shredding upon completion of the study.

b. All of your identifying information will be edited out in the audio-tape transcriptions. My Dissertation Advisor, Dr. Williams, and I will be the only people who have access to the interview tape recordings.

c. In addition to me, the only person who will have access to the full transcription records of the interviews will be my Dissertation Advisor, Dr. Williams.

d. All interview recordings will be kept in a locked, secured place and will be destroyed within two years.

e. I may keep written transcriptions of the interviews for my use in publications or presentations. These transcriptions will use only coded information and you will not be identified in any way.

In the interview, you will be asked about experiences that have caused you to feel morally distressed as a Nurse Manager and about your perceptions of the ethical climate of your hospital. There is a possibility that this may cause you to recall distressing times. If you suffer some adverse response as a result of participating in this study please contact me at the telephone number or e-mail address below.

Your participation in this study is voluntary and you will not be paid for your participation. If you decide not to take part in the study, or if you decide to stop participating at any time, you will not be penalized in any way and all of your contact information and any audiotaped recordings will be destroyed.

It is hoped that the information we gain from this study will provide important information for Nurse Managers and Nursing Administrations and will contribute information that, it is to be hoped, will improve the work environment of Nurse Managers.

If you have questions about the study itself or you are interested in participating, please contact me: Rebecca Porter, MSN, ARNP, (319) 354-3582 or rebecca-b-porter@uiowa.edu .

If you have questions about the rights of research participants, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, Iowa 52242, or call (319) 335-6564, or e-mail irb@uiowa.edu

Thank you for your interest in this study. If you are interested in participating in the study, please e-mail me or tell me when I contact you. I will follow this letter with a telephone call to answer questions. If at that time you are interested in participating, we will schedule a time for the interview. Should you decide not to participate in the study, all of your identifying information will be shredded and destroyed. If you decide to participate in the study, your verbal acknowledgement will be required at the beginning of the tape-recorded telephone call.

Sincerely,

Rebecca Porter, MSN ARNP
PhD Student, University of Iowa

APPENDIX G

OUTLINE OF THE TELEPHONE INTERVIEW GUIDE

Telephone Script for Semi-Structured Interviews

Hello, "Participant." I am Rebecca Porter, a PhD candidate in the College of Nursing at the University of Iowa. Thank you for your interest in this study.

I would like to verify that you understand and agree that this interview is tape-recorded. And, it is important also that you understand that your participation in this study is voluntary. That is, you do not have to answer any questions that you do not want to answer. You can stop the interview at any point and withdraw from the study. Also, all your identifying information, such as your name, the name of your hospital, and the city that you live in, will be edited out during the transcription of this tape recording.

And just to clarify, you work in the United States? And you have never worked in combat or any other war zone?

In this interview, I want to ask you three main questions about an aspect of your work as a Nurse Manager. I am interested in the concepts of moral distress and ethical climate in acute care hospitals. At the end of the interview, I would like to also ask you some demographic questions.

Would you like to continue to participate in this study?

[Note to interviewer: The questions in italics are prompts that will be asked if the participant's answers do not include this information in the course of the conversation.]

1. I would like to start by asking you about moral distress. It is described as a response to a situation when we know the right thing that should be done, but for a variety of reasons, the right thing does not get done. This is a relatively common experience in Nursing. Have you experienced this in your role as a Nurse Manager? Tell me anything you can that will help me understand what that situation was like.
    a. *Did this affect how you did your job?*
    b. *How did this affect you or your personal life?*
    c. *What kinds of things helped you resolve the problem?*

d. *What kinds of things prevented you from resolving the problem?*
e. *Did you think about resigning from your job?*
f. *Who do you discuss this with? (for instance, colleague, mentor, friend, family)*

2. The ethical climate of a hospital is sometimes thought of as how the collective behavior of people impacts things at work. How would you describe the ethical climate in your hospital?
3. When you experienced morally distressing situations at work, what people or hospital policies best helped you to work towards a resolution? What people or hospital policies blocked a resolution to the problem?
4. Is there anything else we have not talked about that you think I should know?

Thank you for your thoughts.

I would like to ask you some questions that will help me understand the demography of the people who have participated in the study. Again, feel free not to answer any of the questions.

<u>Demographic Questions</u>

Age

Geographic location in U.S. (Northern Plains, NE, NW, West, Midwest, Southern, SE, or SW)

Racial identity

Religious beliefs: major or minor world religion, observant/not observant

Highest level of nursing education

Hospital characteristics: university affiliation, religious affiliation, rural/urban/community, number of in-patient beds

APPENDIX H

SAMPLE SCRIPT FOR TELEPHONE AND E-MAIL FOLLOW-UP

Telephone Follow-up

Identify self: I am Rebecca Porter, the doctoral nursing student at The University of Iowa who will be conducting the study about the meanings Nursing Managers have of the ethical climate of their hospital in circumstances that they have found morally distressing.

I sent you the information regarding the study that I am doing with Nurse Managers. I am calling to see if you received the information letter. Do you have any questions about the study? Are in interested in participating in the study? (If yes, will schedule interview date and time. If the person is not interested, will state "thank you for taking the time to think about this. I will shred and destroy all of your identifying information").

E-mail Follow-up

Hello, Participant's name

This is Rebecca Porter, the doctoral student in Nursing at The University of Iowa who will be conducting the study about the meanings Nursing Managers have of the ethical climate of their hospital in circumstances that they have found morally distressing.

I sent you the information regarding the study that I am doing with Nurse Managers. I am emailing to see if you received the information letter. Do you have any questions about the study? Are you in interested in participating in the study? If you are not interested, please let me know and I will shred and destroy your identifying information. If you are interested, could we set up an interview date and time?

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