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Moral Distress

Manuel Silva

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A Major Paper Presented

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Abstract

Moral distress is a common but frequently overlooked concept in the nursing profession, though not exclusive to nursing. Many professionals experience this distress, but nurses encounter this phenomenon more often than other professions. Moral distress can cause many physical and emotional symptoms that affect how a person perceives satisfaction in his/her profession. These include anxiety, fear, frustration, feeling of powerlessness, poor sense of safety and security, nursing turnover, and nursing professionals leaving the profession. This project targeted medical-surgical nurses and aimed to provide them with education to identify moral distress as well as appropriate coping skills that may be used to deal with the moral situation. The AACN Rise Above Moral Distress education plan, which uses the 4 A's of Ask, Affirm, Assess and Act, was utilized for the staff education sessions. Nurses on the unit believed that they knew how to define moral distress, identify moral distress situations, have institutional support services, and are able to be a support resource to co-workers to help identify moral distress situations Comparison of pre-post surveys showed a 40% increase in knowledge, a 30% increase in moral distress confidence and a 15% increase in co-worker support confidence. Institutions often lack required employee education for identifying ethical and moral distress situations or the appropriate coping skills to be utilized. Training on dealing with ethical situations and development of uniform coping skills are needed. Recommendation from this study focused on the need for increased training on moral distress in specific areas.

Table of Contents

Moral Distress

Background and Statement of the Problem

Moral distress is a common but frequently overlooked concept in the nursing profession, though not exclusive to nursing. Many professionals experience this distress, but nurses encounter this phenomenon more often than other professions (Pauly, Varcoe, Storch, & Newton, 2009). Moral distress has been defined in various ways, with the definitions by Jameton (1984) and Corley (2002) cited frequently in the literature. Jameton (1984) identified moral distress as occurring when a situation arises and one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action. Corley (2002) defined moral distress as the painful psychological disequilibrium that results from recognizing the ethically appropriate act, yet not taking it. This occurs because of obstacles such as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations. In addition to there being multiple definitions of the concept, a problem exists with varying and overlapping terminology. Terms like moral integrity, moral residue, moral burden, reactive distress, and ethical sensitivity are some of the words that are used in lieu of identifying the situation as moral distress (Schluter, Winch, Holzhause, & Henderson, 2008).

The concept of moral distress is difficult for an individual to grasp and most individuals do not realize what they are experiencing. When looking at moral distress from the prospective of the nurse, most nurses feel it is part of the job or that there is nothing that they can do about the situation (Maluwa, Andre, Ndebele, & Chilemba,

2012). Moral distress can cause many physical and emotional symptoms that affect how a person perceives satisfaction in their profession. These include anxiety, fear, frustration, feeling of powerlessness, poor sense of safety and security, nursing turnover, and nursing professionals leaving the profession (Weigand & Funk, 2012). Without proper identification of the presence of moral distress and strategies to manage it, nurses can develop psychological and physiological impairments (Schluter et al., 2008). Depending on the situation and the frequency, nurses who experience moral distress are more likely to escalate to the point of burnout, the psychological conditions that results from ineffective coping strategies from stressful situations (Edward & Hercelinskyj, 2007). The effect of moral distress needs to be analyzed further so that changes can be made to promote a more healthy and ethical environment (Pauly et al., 2009).

Health care workers have little or no knowledge related to moral distress. Nurses in particular deal with many stressful situations throughout the day, many of which lead to external and internal conflict. This conflict may provide an ethical dilemma for the individual nurse and moral distress can develop from these conflicts. Appropriate education and coping skills are needed or nurses will begin to experience detrimental effects that impact their behavior and job performance. Supportive climates and environments have been shown to foster nurses' recognition and coping with moral issues without going into distress (Pendry, 2007). In contrast, a poorly supported ethical environment leads to a decrease in job satisfaction (Pauly et al., 2009; Schluter et al., 2008).

Research on moral distress has focused mainly on the critical care nurse and is lacking for the general medical-surgical floor nurse. Decreased job satisfaction of the medical surgical nurse resulting from moral distress needs to be studied and addressed (Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008). This project targeted medical-surgical nurses and aims to provide them with education to identify moral distress as well as appropriate coping skills that may be used to deal with the moral situation.

Literature Review

An extensive literature search was performed utilizing CINAHL and web searches of related websites. The search terms included “moral distress”, “burnout”, “ethical climate”, ethical environment”, “moral sensitivity”. The search results were narrowed further by adding the terms “acute care”, “medical surgical”, “nursing” and by using only texts published in English. The time period used for the literature review was limited to the past 10 years.

Moral Distress Definition

Moral distress has been defined in various ways over the years. The first definition was proposed by Jameton (1984) who identified moral distress as occurring when a situation arises and one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action. According to Corley, Elswick, Gorman, and Clor (2001), moral distress is the painful psychological disequilibrium that results from recognizing the ethically appropriate act, yet not taking it, because of obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations. Lutzen, Cronquvist, Magnussion, and Anderson (2003) separated moral distress into three parts: moral sensitivity to patients’ vulnerability; experience of external prevention of performing moral actions; and having no control over a situation. Sorlie, Kihlgren, and Kihlgren (2005) termed moral distress as what happens when situations arise that pose conflicting demands, their attempts at acting are hampered or they perceive their actions as wrong or inadequate.

A broader definition was proposed by Sporrong, Hoglund, and Arnetz (2006): moral distress was viewed as encompassing negative stress symptoms emerging in situations involving ethical dilemmas, when the healthcare provider feels incapable of protecting all needs and values at stake. Pendry (2007) identified moral distress as the physical or emotional suffering that is experienced when constraints (internal or external) prevent one from following the course of action that one believes is right. According to Rittenmeyer and Huffman (2009), moral distress is an experience in which nurses feel they are unable to fulfill professional duties for patients secondary to constraints of the institution. When nurses cannot do what they think is right for the patient, integrity and authenticity are decreased and feelings of disempowerment occur.

Moral distress is an approved nursing diagnosis and was included in the 2007-2008 edition of *Nursing Diagnoses: Definitions and Classifications*. "Moral distress is a response to the inability to carry out one's chosen ethical/moral decision/action" according to NANDA (2012, p. 398). The American Association of Critical-Care Nurses (AACN) also realized the importance of moral distress as a serious problem in nursing and developed its own definition and policy position. According to AACN (2004), moral distress occurs when the nurse knows the ethically appropriate action to take, but is unable to act upon it. The nurse thus acts in a manner contrary to his/her personal and professional values, which undermines their integrity and authenticity. The AACN policy position acknowledges that moral distress is a critical, frequently ignored, problem in healthcare work environments. Moral distress inhibits job satisfaction and restricts nurses from providing optimal patient care when the phenomenon is not addressed. A

healthy work environment should be created to alleviate the harmful effects of moral distress. AACN goes further to recognize that program implementation to address the effects of moral distress is the responsibility of the nurse and employer (AACN, 2004).

The authors of a study on ethical beliefs, conscientious objection, and influencers of moral distress provided a different perspective of the definition of moral distress. The definition formulates that moral distress can happen when there is a violation of one's moral integrity. The authors suggested that to further the understanding of this definition, moral integrity must be defined. Moral integrity was defined as living up to what one believes is right and wrong (Davis, Schrader, & Belcheir, 2012).

Controversy is also evident about the concept of moral distress. A brief article by Johnstone (2013) challenges the notion of moral distress and identifies reasons as to why the notion of moral distress should be challenged. Johnstone evaluated three domains to respond to the notion of moral distress. The first domain represents clinical situations like end-of-life decisions, inadequate informed consent, and working with incompetent practitioners. The second domain is internal constraints, which consists of lack of moral competencies, perceived lack of autonomy, powerlessness to act, lack of knowledge and understanding of the situation. External constraints represent the third domain. External constraints can be hierarchies, inadequate communication, hospital policies, and conflicting priorities with different areas of nursing come different causes of moral distress. Johnstone noted that individuals responded differently in the same situation and that people will construct, interpret, and respond to issues based on their own personal motivations and expectations. The author also challenges moral distress scales as being

pre-coded to present situations as involving moral distress. The author believes that one needs to know the nurses personal ethical ideologies that frame their ethical decision-making by which they justify their conduct, and that until this is done, moral distress will remain dubious.

For the purpose of this Master's project, moral distress was defined as the "inability of a moral agent to act according to his or her core values and perceived obligations due to internal and external constraints" (Ulrich, Hamric, & Grady, 2010, p. 20). This definition was chosen because it identifies that there are internal and external constraints and not just institutional constraints.

Moral Distress: Related Terms

It is important to understand some of the terms that are used or even confused with moral distress, which may lead to poorly defined conclusions. These terms were identified in a moral sensitivity and ethical climate literature reviews conducted by Schluter et al. (2008) and are indicated below:

- Ethical climate is the organizational conditions and practices that affect the way difficult patient care problems, with ethical complications, are discussed and decided;
- Ethically sensitive environment is an environment where nurses can identify moral issues and understand the effects of their actions on the outcome of the situation;
- Ethical sensitivity states that direct caregivers can identify patient needs by interpreting verbal and non-verbal behaviors;

- Reactive distress is a sensation that people feel when they do not act on the initial feelings of distress;
- Moral burden is a burden from moral values that causes a problem or situation;
- Value conflict is a conflict with the nurse's view of patient care plans and management strategies. They represent what it means to be a good nurse, and how one should act as a good nurse;

(Schluter et al., 2008, p. 305-307)

It is important to distinguish between two terms that are frequently used in the literature: burnout and moral distress. Burnout is viewed as a consequence of unresolved moral distress. Characteristics of burnout include chronic fatigue, exhaustion, sense of being under siege, increased risk taking, negativity, cynicism, and self-criticism (Edward & Hercelinskyj, 2007).

Moral Distress: Etiology, Contributors, and Related Research

Moral Distress Etiology and Contributors. Moral distress is noted to be a growing problem in the health profession (Ulrich, Hamric, & Grady, 2010). Ulrich et al. (2010) aimed to show that open dialogue of direct care workers is warranted and interdisciplinary education and collegial practice can be strategies to reduce moral distress. The design used a case study and a reference to a book by a transplant surgeon to identify moral distress that is experienced by physicians and nurses. Methods to be utilized would be to have supportive mechanisms for health care providers. Facilities need to move to more open collegiality and shared practice models to help decrease the

incidence of moral distress. Ethics course and interdisciplinary education should be provided to the staff. The article does not identify results, but the anticipated results would be for health care workers to speak up for the patient's welfare about ethical concerns. This will give moral distress recognition and provide a sense of resolve and caregivers will be able to respond to difficult ethical situation with complex health care needs with more confidence.

Because moral distress is a difficult to define concept that also overlaps with other related concepts, the literature frequently fails to isolate moral distress when identifying contributors. Taylor and Barling (2004) identified several contributors to workplace fatigue, stress, and burnout. These include employment insecurities, casualization of the workforce, issue with management and systems, difficulties with the nature of the work, inadequate resources and services, problems with other staff, aggressive patients, undervaluing of patients and nurses, fewer fundamental rewards, emotional constraints of the work setting, nurse relationships, and horizontal violence were contributors. Ulrich et al. (2010) noted that poor communication, inadequate collaboration, powerlessness, and lack of support were important contributors. Edward and Hercelinskyj (2007) discussed that many of the rewards that attracted nurses to join the profession have disappeared or diminished. The common signs of burnout were identified and the idea of resilience was introduced. Resilience occurs by supporting a person's strengths and helping them move toward functional coping. Resilience factors can be intrapersonal and environmental. The cognitive factors encompassed characteristics of optimism, intelligence, and humor. Resilient characteristics can be assessed by informal peer support, informal consultation,

formal consultation, supervision, and reflective practice. The authors emphasized the importance of reflective practice within the existing organizational structure to promote the learning of resilience behaviors (Edward & Hercelinskyj, 2007).

Rittenmeyer and Huffman (2009) identified causes of moral distress as including unrecognized power hierarchies, inability to influence medical decisions related to the care of the patient, inability to advocate for the patient, and institutional constraints. End-of-life issues, staffing patterns, nurse-physician conflicts, inadequate resources, and protection of human rights and dignity were also identified as potential factors that would cause moral distress (Davis, Schrader, & Belcheir, 2012).

Related Research. There is little data on moral distress for nurses working on medical and surgical acute care units. The purpose of a study by Rice et al. (2008) was to determine the contributing factors to moral distress in medical and surgical nurses. The study was a prospective cross-sectional survey of nurses with different patient populations at an acute care hospital. A 200 bed acute care hospital in the southwest was the survey site and 284 nurses participated. The hypothesis was that age, nursing experience, and the nature of the patients' illness would affect the experience of moral distress. Participants were asked to complete the Moral Distress Scale, which was developed by Corley et al. (2001) to measure the intensity and frequency of moral distress. The survey includes 38 situations, which are categorized into several subscales including individual responsibilities, care not in the patient's best interest, deception, and euthanasia. Results of the survey showed the moral distress was uniformly high among the six categories, with futile care resulting in the highest moral distress. The prevalence

of moral distress in regard to futile care ranged from 67-87%. In the category of nursing practice, the prevalence ranged from 57-92%. Recommendations to assist in managing moral distress included open dialogue, ethics rounds, SBAR communication, patient care conferences, open group discussions, simulation, debriefing sessions, pairing new nurses with more experienced nurses, encouraging palliative care, and patient advocacy (Rice et al., 2008).

Since this is relatively a new concept, research is being conducted to identify areas that may contribute to moral distress such as the ethical climate and environment. Research suggests that ethical climate can contribute to moral distress. Poor ethical climates that lead to moral distress can cause decreased nursing satisfaction, attrition, and unsafe patient care (Hart, 2005; Varcoe et al., 2004; Wilkinson, 1988). The aim of a study by Pauly et al. (2009) was to describe moral distress levels, perceptions of the ethical environment, and the relationship of moral distress and ethical climate. The purpose of this study was to describe the level of moral distress of nurses, assess their perceptions of the ethical climate, and the relationship between moral distress and ethical climate. The study hypothesized that a negative perception of the ethical environment would correlate to increased moral distress levels. The method was a cross-sectional survey that used the Moral Distress Scale, the hospital's ethical climate survey. Surveys were mailed to a randomly selected sample of 1700 nurses with 300 nurses (22%) responding. The results showed that the levels of moral distress and ethical climate were significantly correlated ($r = -0420$; $p < 0.01$). The Hospital Ethical Climate Survey had a mean score of 3.88 on a scale that ranged from 1-5. High moral distress was noted with

what one considers unsafe staffing levels (mean = 4.63) and competency of staff and other health care providers (means 4.47-4.63). The mean moral distress intensity was 3.88 on a scale of 0-6. The highest item with an intensity mean score of 4.63 was working with staffing levels that the nurse considers unsafe. When looking at moral distress frequency, the highest item from this study was again unsafe staffing levels with a mean of 2.78 and a range of 0-4.39. The correlation of moral distress frequency to moral distress intensity was 0.412 ($p < 0.01$). It was noted that even with low moral distress frequency, the experience was intense for the nurse when it happened (Pauly et al. 2009).

Moral distress is an international issue. Developing countries face great challenges including country pandemic concerns, inadequate material resources, inadequate staffing, and lack of incentives. Hospital environments have outdated equipment and work conditions that decrease the quality of care provided. Maluwa et al. (2012) explored the moral distress in nursing practice in Malawi. The aim of the study was to identify nurses' knowledge of moral distress, identify its causes, find support services that are available, and assess coping mechanisms used by distressed nurses. The study used a descriptive and qualitative approach. Open-ended questions were used and participants were able to openly express themselves. The participants consisted of 20 female nurses. Participation was voluntary and IRB and institutional consent was obtained. Responses were tape recorded and written. Results included five main themes: knowledge and experience; causes of moral distress; effects of the experience of moral distress; coping mechanisms; and desire for support systems. Malawi nurses did

experience moral distress, but they did not know the term or have any understanding of what they were experiencing. The study further showed that the problem of moral distress in Malawi is multi-cultural and multi-healthcare institutional problem. The authors concluded that Malawi nurses experience moral distress regardless of the facility, age, or work experience. The main causes of the distress were inadequate resources, conflicting policies, and disrespect from peers, managers, guardians, and patients. Religion and family were important coping mechanisms for these nurses, and the more experienced nurses were more resilient towards moral distress (Maluwa et al., 2012).

Moral Distress Measurement

Morris and Dracup (2008) identified the need to measure moral distress. A case study design was used to review a situation of futile care that physicians and nurses may have to experience in their careers. The primary purpose of the case study approach was to identify areas of stress from futile care: the woman in the case study had cancer and was hospitalized. She was planning on being discharged with follow-up to a hospice program. The patient became septic the night before discharge, and the family pursued aggressive treatment. After 112 days in the hospital, the patient died. Two areas of stress resulting from futile care were described. The first area was the inability to achieve appropriate pain control or patient suffering, and the second was the expenditure of medical resources on an individual that was not going to survive. The authors also identified ways to address moral distress. Nurses need to realize the hazards of moral distress and the resources that are available to assist with this challenge. Health care systems need to establish climate monitoring systems to identify moral distress situations,

analyze these systematic issues, and make corrective actions. Stress-barrier precautions and a scale for moral distress could help to promote dignity and respect for patients and staff in a positive, professional manner, which will in turn prevent harm to staff. The authors encouraged individuals to read the AACN's policy statement on moral distress to help reduce the health risk of health care professionals in ethical situations (Morris & Dracup, 2008).

A moral distress questionnaire was developed in a study conducted by Eizenberg, Desivilya, and Hirschfeld (2009). The purpose of this research was to develop and test a moral distress questionnaire that was culturally sensitive and could be applied to different settings. The design employed mixed methods: the first phase used an exploratory case study and the second employed a questionnaire that was developed based on results from the first phase. In phase one, 30 Jewish and Muslim nurses participated in five focus groups, each composed of individuals with different work positions and settings. The sessions were tape-recorded and transcribed verbatim. Qualitative methodology experts analyzed the data for themes independently. Results from these sessions concluded that moral distress was a result of external or institutional constraints. Three notable constraints identified were insufficient resources, understaffing and insufficient or inappropriate space (Eizenberg et al., 2009).

The qualitative phase of the exploratory case study served as the basis for the quantitative measure, as well as two established surveys, the SCQ and the MDQ. The authors developed a Likert type scale for data collection. The questionnaire was completed by 179 nurses. Results showed three different factors that were identified as a

representation of moral distress: problems with work relationship of staff; problems from lack of resources; and problems from time limitations. The measurement tool did have acceptable reliability with a Cronbach alpha of 0.79 reported. Evidence of validity for the Israeli sample was presented. The study concluded that the questionnaire could be used for cross-cultural research, but culture specific adaptations would be necessary. (Eizenberg et al, 2009).

Development of the Moral Distress Scale (Corley et al., 2001) was based on the theoretical frameworks of Jameton (1984), House and Rizzo's role conflict theory (1972), and Rokeach's (1973) theory on values and value systems. Jameton's (1984) work was critical in developing the concept of moral distress in nursing. House and Rizzo's theory noted that role conflict occurs when dual forces of supervision impose conflicting professional expectations (House and Rizzo, 1972). Rokeach's explication of how a person's values and value system motivate behavior acknowledges that internal conflict can occur when the nurse's own value system is not in line with external value systems (Rokeach, 1973). Intrinsic to the role theory and concept of values is the idea of autonomy. This is defined as the power to do what one recognizes should be done or keeping responsibility and power in equilibrium (Corley et al., 2001). Nurses may perceive that their professional autonomy is under siege because nurses often have more responsibility than authority.

The Moral Distress Scale was developed through the identification of moral problems in the hospital setting and from content analysis of staff interviews. The final scale resulted in items reflective of identified moral problems. The scale initially used a

5-point response format, which was changed to a seven item response Likert format secondary to lack of variability in the sample response. The Moral Distress Scale has become widely used in moral distress research, has demonstrated reliability and validity, and was determined to be an appropriate instrument to measure moral distress among nurses when caring for adults in the hospital setting (Corely et al., 2001).

Moral Distress: Impact

Impact on the individual. Nurses often do not speak of moral distress, but when explored, they mention the related symptoms of anguish, sleeplessness, nausea, migraine, headaches, gastrointestinal upset, tearfulness, a sense of isolation, and providing futile care (Pendry, 2007). Nurses need to recognize moral distress in order to be able to move toward the process of resolution. Recognition of moral distress is a key component to help improve the outcome of nursing retention (Pendry). Lang (2008) identified moral distress characteristics as including increased patient pain, longer hospital stays, inadequate care, inappropriate care, poor communication skills, and lack of trust, defensiveness, and increased intra-professional. The impact of moral distress included nurses leaving their positions and the profession, increased patient pain, longer hospital stays, inadequate care, inappropriate care, decrease in quality of care, increased intra-professional conflicts. These impacts ranged from generalized to position specific, and the author noted that the effects can negatively impact the health care professional, the facility, the nursing profession, and society. Derived from a comprehensive review of the literature, Schluter et al. (2008) identified moral distress as resulting in significant physical and emotional problems including headaches, anger, guilt, neck pain, muscle

aches, stomach troubles, disgust, sadness, discouragement, powerlessness, unsuccessful advocacy, frustration, loss of self-worth, diarrhea, headaches, depression, disengage from family and friends,

Davis et al. (2012) conducted a study with nurses in Idaho. The aim of this exploratory study was to ascertain the influencers of ethical beliefs, influencers on moral distress, and conscientious objection. Ethical beliefs were deemed as one's personal moral code and individual beliefs or right and wrong. Ethical decisions were described as an individual choice and differ from individual to individual. Moral distress happens from a violation of one's moral integrity and is associated with the characteristics of anger, anxiety, guilt, sorrow, frustration, and/or helplessness. Rest's model of ethical decision-making was used as the framework to guide this study.

A voluntary 30 item survey was included with the online license renewal for 1144 registered nurses in the state of Idaho. Results showed influencers of ethical beliefs to be work/life experiences, professional code of ethics, family values, religious/spiritual beliefs, governing laws/policies and political views. Ethical beliefs were influenced more by work or life experiences than professional code of ethics. Nurses whose ethical beliefs were influenced more by religious beliefs had higher levels of moral distress and showed greater differences with conscientious objection. The study concluded that moral distress can cause emotional and physical withdrawal, inability to cope, decreased self-esteem, inability to provide good patient care, decreased job satisfaction, turnover, burnout, nurses leaving the profession, and increased nursing shortage. These authors identified a need for policy development and environmental changes for open discussion

of values and ethical beliefs. Supportive environments need to be created and nurses need to be aware of the signs and symptoms of moral distress. The concept of conscientious objection should also be able to be discussed freely (Davis et al., 2012).

Systems impact. A comprehensive literature review was conducted (Schluter et al., 2008) to answer the question if effects of unresolved moral distress and poor ethical climate impact nursing turnover. To be included in the review, studies needed to address the question: 'Does unresolved moral distress and poor organizational ethical climate increase nurse turnover?' Of the 1503 articles obtained from the search results, nine met the inclusion criteria. Six of the articles used a quantitative design and the other three were qualitative. Findings revealed causes of moral distress to include poor-quality care, futile care, unsuccessful advocacy, raising unrealistic hope, which is influenced by educational levels and peer support. Moral distress negatively impacted the physical and mental health of nurses, provision of care, job satisfaction, and staff turnover. In addition to numerous impacts on the individual, moral distress was identified as resulting in disjointed care, poor communication, limited patient advocacy, less personalized care, decreased job satisfaction, and relationship to increased nursing turnover. Data supporting the assumption that poor ethical climate and moral distress cause staff turnover were not clearly reported or measured. The authors noted that distress can be controlled by an ethically supported environment, and suggested that managers and peers must feel free to advocate for each other (Schluter et al.).

Overall impact. Huffman and Rittenmeyer (2009) conducted a systematic review of moral distress in the hospital environment. The authors considered qualitative

evidence that illuminated moral distress of professional nurses from the time period of 1995-2008. From the initial search results of 1691, 39 qualitative studies were reviewed and analyzed to develop four syntheses related to moral distress. All studies were qualitative and descriptive exploratory in nature. Participants were nurses working in hospitals that had experienced moral distress. Data was extracted and synthesized by QARI.

General statements were identified, rated and categorized, then subjected to a meta-synthesis for evidenced based practice. Outcomes of interest included, but were not limited to, stress reactions, psychological reactions, feelings of powerlessness, a desire to leave the profession, a perceived lack of administrative support, the stress of being in the role of patient advocate, time/staffing constraints, the devaluing of patient wishes, futile care, unnecessary patient pain and suffering, and perceived employment risk when voicing concerns. This review produced 102 findings that were aggregated into 11 categories (Rittenmeyer & Huffman, 2009).

After analyzing the categories further, the results were synthesized into four findings: human reactivity; institutional culpability; patient pain and suffering; and unequal power hierarchies. Human reactivity noted that nurses in moral distress respond with differing biopsychosocial responses. Institutional culpability represents the adverse effects of the system, health care constraints, and patient advocacy. Patient pain and suffering included the devaluing of patient wishes, provision of futile care, and patient suffering. Unequal power hierarchies included conflicting professional goals and values and unequal authority. Moral distress resulted in biological, psychological, and stress-

related reactions. Nurses impacted by moral distress can experience burnout, leave their position, leave the profession, or find a less stressful job. Nurses need to recognize moral distress and be aware of its adverse impacts. Solutions to stop the progression of moral distress in nursing include opportunities to express concerns, be involved in decision making, mutual respect, and ability to practice without violating the individual's core values. The study showed the importance of acknowledgment of moral distress, education, nursing expression, alignment with core values, and the need for further research of moral distress and power hierarchies (Rittenmeyer & Huffman).

Rittenmeyer and Huffman (2009) identified recommendations for practice from the institutional standpoint, including: recognize nursing specialties that are more vulnerable to experience moral distress; consider the implementation of the AACN framework for addressing moral distress; provide support that is genuine and nonjudgmental that ideally would be provided by nurses; provide educational programs to identify moral distress and its effects; give nurses a voice to express concerns and give input on problem solving; create an environment of shared respect that supports autonomy and acknowledges contributions; and the respect of nursing value with holistic care in the health care facility. The professional nurse should have access to and be a part of the ethics committee, and should not be coerced to violate their core beliefs about good nursing care when advocating for a patient. Further research implications should include evaluation of the effectiveness on support strategies in address moral distress and preventing burnout. The review pointed out the need to look at strategies to equalize a

nurse's voice and decrease the sense of powerlessness in a patient-centered care environment (Rittenmeyer & Huffman).

Moral Distress: Other Research

A phenomenological approach was utilized to obtain narratives of nurses working in an overcrowded accident and emergency department. The aim of the study by Kilcoyne and Dowling (2008) was to bring forth nursing issues with overcrowding in the Accident and Emergency (A&E) department. The design used unstructured interviews with an adopted interpretive phenomenological approach. The sample included eleven A&E nurses working in the West of Ireland. Reliability was established by the study participants confirming the interpreted findings that had been recorded by the first author and external peer review was also obtained.

The results showed three main themes as well as with identified sub-themes. The main themes were lack of space, elusive care, and powerlessness. Lack of space had the subsets of poor service delivery, health and safety, and infection control issues. Elusive care included the areas of lack of respect and dignity, unmet basic human needs, and hovering. The third theme of powerlessness had the categories of not feeling valued, moral distress, and stress and burnout. Narratives illustrated the impact of unresolved moral conflicts on reduction in the quality of care, creating burnout, and caregivers leaving their jobs (Kilcoyne and Dowling, 2008).

The authors concluded that the central issues of powerlessness, lack of space, and inability to give quality care contribute to moral distress and burnout. Their recommendations were to involve the nurse in the decision-making process, listen to the

nurses, and acknowledge their expertise. Nursing managers were identified as instrumental in ensuring focused quality care and play a central role in supporting nurses' strategic attempts to manage the moral and psychological issues within the emergency department. The constant risk of moral and emotional distress in the complex and multifaceted emergency department cannot be overlooked (Kilcoyne and Dowling, 2008).

A reflective review by Houghtaling (2012) used two case study scenarios to explore the idea that the dilemma of moral distress and emotional suffering affect the individual's conscious and unconscious cognitive coping behaviors. This distress also alters one's ability to deliver a professional standard of care that is expected of them. The author identified two caring concepts to help articulate and explain the role of moral distress in trauma nursing: enduring and suffering. Enduring requires restraining emotions to get through a procedure or situation. Suffering is a threat or perceived threat to the integrity of the nurse. Trauma nurses need help in recognizing moral distress and understanding the damage that the distress can inflict. With this recognition, the trauma nurse can maintain a sense of well-being, process the situation, feel the impact, put it into perspective, prudently care, and respectfully move forward. Suffering will change to a compassionate action for the trauma nursing if the above actions are followed. This author urged for more research to help cope and generate evidenced based strategies for the trauma nurse (Houghtaling).

Literature Summary

After reviewing all the relevant literature, it is evident that there is overall consistency. The literature supports that moral distress is a common occurrence in nursing practice. The literature clearly reveals the important determinants and the widespread impact that result from the experience of moral distress. The concept of burnout seems to be more widely researched than moral distress, even though the literature supports a strong correlation with moral distress and burnout (Rice et al., 2008).

The literature supports the need for education and organizational support to combat the effects of moral distress. A study of moral sensitivity (Schluter et al., 2008) and another study of nurses' perceptions (Pauly et al., 2009) stressed the importance of the ethical climate in relation to the experience of moral distress and moral residue. The dilemma of moral distress and nurse retention can be improved by ethics education according to Lang (2008). A major problem seems to be the lack of research evidence to support the relationship of moral distress to nursing issues like turnovers, job satisfaction, unsupportive climates, behavioral changes, and emotional consequences, (Schluter et al., 2008; Pauly et al., 2009). More research is needed to show the significance of the problem and to provide evidence based practices for organizations to support and educate their staff. Moral distress is an on-going problem that needs to be brought to the forefront of research and organizational education programs.

Previous studies have shown education sessions to be useful in the critical care areas. The acute care medical-surgical nurse needs to have these resources available. The purpose of this project was to provide nurses employed on a medical-surgical unit

with education to identify moral distress as well as appropriate coping skills that may be used to deal with the moral situation.

Next, the theoretical frameworks that guided this project will be presented.

Theoretical Framework

Watson's Philosophy and Science of Caring was chosen to guide this research, as well as Lazarus' theory of stress and coping.. Watson has a master's degree in psychiatric and mental health nursing and a Ph.D. in education psychology and counseling. Also, Watson founded and was the director of the Center of Human Caring at the Health Sciences Center in Denver. She believed that caring is pivotal in nursing and promotes health better than a simple medical cure and that caring attitude is derived from the culture of the environment in which the nurse practices. Watson identified a holistic approach as a key component of nursing and her philosophy of caring expresses the idea that caring can be demonstrated and practiced (Watson, 2008).

A caring environment will accept a person for who they are, and envision what they may be. Nurses universally appear to be torn between human caring values and the values that attracted them to the profession (Watson & Foster, 2003). Conflict with human caring values also occurs with technologically, high paced, task-oriented biomedical practices, institutional demands, heavy workloads, and outdated practice patterns (Watson & Foster, 2003). Watson's theory has three factors that make it unique (Watson, 1997). The first is the lived experience of a caring moment shared by the patient and the nurse. Second, the mind, body, and spirit are acknowledged to keep the dimension of wholeness to the person. Finally, the theory acknowledges the different ways of knowing which can be empirical, aesthetic, ethical, and personal knowing. Watson's Caring Model includes 10 carative factors, with the first three being identified as instrumental in accomplishing the seven that follow. The first three factors are

forming of a humanistic-altruistic value system, installing faith and hope, and cultivating sensitivity to self and others. These three factors are the philosophical foundation for the science of caring from Watson (2008).

The idea of caring and effect of caring has been disregarded in the past. According to Watson, many studies did not involve the concept of care because it could not be scientifically analyzed in situations. Recent literature from theorists like Watson shows this to be a mistake. "Caring likely has a return on investment that surpasses all other technology, pharmacotherapy, or system that has been developed to date for health care" (Nelson, 2011, p. 215). Recent studies by the Caring International Research Collaborative foster the idea of caring science and facilitate theorists like Watson to educate those who are practicing in the health care profession. Those committed to the science of caring have set aside their egos and believe in partnerships of sharing research and resources.

Watson continues to bring diverse concepts and ideas that contribute to transformative models. One of the premises of caring science is the acceptance that spiritual and ethical dimensions are driving factors in the human care process. Watson believes that how nurses care for others can affect human development. Another belief is that nurses make social, moral, and scientific influences to the public. Watson continues to refine the theory relationships to the current way she believes human caring and spirituality are impacted. Watson's work is currently being used for education and clinically on an international basis. (McEwen & Willis, 2011)

This model is appropriate for the moral distress problem because it is able to look from a holistic view and believes in exploring the spiritual, ethical, social and scientific contributions to nursing care. Watson's model also explores the hierarchy of needs that would be applicable to what needs a nurse may be lacking when the morally distressful situation occurs. Two of the models assumptions fit perfectly with the problem of moral distress. The first states that "effective caring promotes health and individual and family growth" (Watson, 2008). If a nurse feels that they are not providing effective care, the individual will not experience growth and the person's health will be in jeopardy. The second assumption that matches the problem is a caring environment offers the potential for development of oneself (Watson, 2008). This shows that the environment has a significant outcome on the development of the care provider. The relationship of moral distress and avoidance, doing the bare minimum, resentment, anger, and frustration are currently being researched. The literature review notes that a poor environment is a major contributor to the issue of burnout. The essence of this model and the deep understanding of the individual nurses' self, make this model the perfect choice for the problem of moral distress in acute care medical surgical nursing.

The overall principles of Watson's theories were utilized for the project, with Lazarus' theory of stress and coping specifically guiding the educational sessions. Lazarus' theory examines how people cope in stressful situations (1984). Stressful situations are viewed as a process according to Lazarus. The process involves how one thinks and acts in a given situation but also includes any changes as the situation goes on. Lazarus framed coping as a process of appraisals and reappraisals during a given

interaction, which brings about dynamic changes. Coping consists of cognitive and behavioral efforts to manage the specific demands that tax or exceed a person's resources (Lazarus & Folkman, 1984). This theory cites two major factors that accompany stress; person-environment relationship and appraisals. Three cognitive appraisals, primary, secondary and reappraisal, are identified. Primary appraisal deals with the individual's initial judgment about a stressor. How one responds to the event constitutes secondary appraisal and reappraisal is the appraisal that comes from new or additionally received information. Lazarus believed that coping is an evaluation of the perception of a threat, or an appraisal (Lazarus & Folkman, 1984).

A person's evaluation of a stressor was called a cognitive appraisal and stress happens when an event exceeds the person's resources (Lazarus & Folkman, 1984). Management of the appraisal is what is considered coping (Lazarus & Folkman, 1984). Two types of coping are identified. They are problem-focused and emotion-focused coping. A change in the person-environment relationship is considered to be problem-focused; when the meaning of the situation is changed, it is considered to be emotion-focused. A person cannot begin reappraisal until they have coped with the particular situation. Reappraisal allows for future changes and outcome information to be obtained from the event at hand. When successful coping has been obtained, the person is said to have entered into adaptation, and this is when a person can survive and flourish. Three different areas are affected in this state and they are interactive: somatic health, psychological well-being, and social functioning (Lazarus & Folkman, 1984). When one area is impacted, the other areas are affected secondary to their interdependence. An

important area to focus on during a stressful event of an individual is the meaning of the stressor to the individual and the individual's available resources and supports.

Next, the methodology will be identified.

Methodology

Purpose

The purpose of the project was to provide nurses employed on a medical-surgical unit with education to identify moral distress as well as appropriate coping skills that may be used to deal with a moral situation.

Design

This project included a pre-survey, an intervention and a post-survey. An education session (the intervention) on moral distress was provided by the researcher to medical-surgical nurses and a pre and post-survey was administered to evaluate knowledge gained.

Sample and Site

Nurses on 4 West, a medical-surgical unit of an acute care facility, the Miriam Hospital, were the sample participants. Potential subjects had diverse years of medical-surgical nursing experience. The sample consisted of mostly female participants due to the low ratio of males on the medical-surgical units. Convenience sampling was used.

Procedures

IRB reviews were obtained from the Lifespan IRB and the Rhode Island College IRB. The manager of the medical-surgical unit was aware of and supported the educational plan and time needed to perform the education to the staff.

The staff nurses were informed about the educational class through flyers posted on the unit, discussions at nurse meetings, reminders at collaborative rounds, and

screensavers that identified the time and place of the educational meetings. Times and dates were coordinated with the unit manager. A copy of the flyer is in Appendix A.

Educational Program

The American Association of Critical Care Nurses' teaching tool-kit on moral distress (AACN, 2004) was utilized to provide the education to the staff nurses. The Rise Above Moral Distress education plan from the AACN uses the 4 A's of Ask, Affirm, Assess, and Act to help identify and cope with situations that may be a threat to an individual nurse's moral integrity. Table 1 on the next page illustrates The Rise Above Moral Distress education plan that was implemented.

The educational program was developed by members of an ethics work group created by the AACN. This initiative was undertaken because compelling evidence indicated that moral distress has a negative impact on the healthcare work environment. The AACN Position Statement on Moral Distress acknowledged that one in three nurses experience moral distress and half of the nurses studied left their position, or nursing altogether, due to moral distress. The position statement also identifies the impacts of moral distress as acting against one's conscience, losing capacity for caring, avoiding patient contact, failing to give good physical care, withdrawing from the bedside, barely meeting the patient's basic physical needs, leaving the profession, and experience physical and psychological problems (AACN, 2004).

Table 1

Rise Above Moral Distress: The 4 A's (AACN)

ASK	**Ask appropriate questions.** "Am I feeling distressed "or showing signs of suffering? Is the source of my distress work related?	**Goal: You become aware that moral distress is present.**
AFFIRM	**Affirm your distress and your commitment to take care of yourself.** Validate feelings and perceptions with others. Affirm professional obligation to act.	**Goal: You make a commitment to address moral distress**
ASSESS	**Identify sources of your distress.** Recognize there is an issue but may be ambivalent about taking action to change it. Analyze risks and benefits.	**Goal: You are ready to make an action plan**
ACT	**Take Action** Implement strategies to initiate the changes you desire. **Maintain Desired Change**	**Goal: You preserve your integrity and authenticity.**

The tool-kit was designed to help participants recognize and name the experience of moral distress. Furthermore, the program affirms the professional obligation of nurses and employers to act and address moral distress dilemmas. Another benefit of the

educational tool was to acknowledge the identification of professional and institutional resources to alleviate impacts of moral distress situations (AACN, 2004).

Implementation

The educational session took place prior to the monthly staff meetings. Two additional time frames were offered and coordinated with the nurse manager, with target times in the afternoon and one in the evening. The nurse manager determined that participation in the educational sessions was mandatory however nurses were not required to complete the pre and post-survey. The meetings took place in a quiet area where interruptions were minimized. Face to face meetings allowed for questions and enhancement of concept understanding by visual, auditory, and repetitive methods of communication. The education session was based on Lazarus' framework and was completed by the researcher. It required approximately 60 minutes of the staff nurses' time, as illustrated in Table 2 on the next page.

Table 2

Content, Objectives, Timeframe, and Materials

Content	**Objective**	**Timeframe**	**Materials**
Introduction of class and completion of pre-survey		5 minutes	Pre-survey
Nurses' identification of experiences with moral distress	Identify moral distress situations	10 minutes	Classroom exercises from participant guide
Group discussion	Use 4 A's to guide experiences of moral distress situations to help participants affirm and validate feelings/ perceptions in situations of moral distress using Lazarus appraisal and reappraisal framework	10 minutes	Facilitator guide
AACN position statement, moral distress definition, review of 4 A's	Verbalize importance of moral distress and define it. Describe the 4 A's	15 minutes	Power point presentation slides include in the toolkit
Clinical situation evaluation	Use the 4 A's in a clinical situation to identify and assess personal and environmental sources of moral distress	15 minutes	Case study from participant and facilitator guide
Review and use of reference cards	Demonstrate how reference cards can be used to manage moral distress. Questions from participants.	5 minutes	Laminated cards and 4 A's poster

On the day of the scheduled program, participants were briefly introduced to the purpose of the project. Nurses who wished to participate were then asked to complete the pre-survey (Appendix B), which did not include any identifiers. Participants received a poster and a classroom guide while completing the pre-survey. After completion, they were asked to place the pre-surveys in a sealed drop box that was in the room used for teaching. The participants were informed about the post survey (Appendix B) and program evaluation survey (Appendix C) at this time.

The 4 A's were reviewed in depth, and the nurses were given laminated cards to remind them of what the 4 A's represent. Participants had been asked about how they cope and act in a moral distress situation. Alternate coping actions were elicited from the group and reappraisal of initial action was discussed.

Along with a poster of the 4 A's, each participant received a participant guide with case studies, self-assessment exercise, classroom exercise of a situation of moral distress, classroom exercise of moral distress in the workplace and its challenges, self-care tips, and the ANA Code of Ethics for Nurses: 9 Provision Statements (Appendix D). The participant guide was used throughout the teaching process to reinforce the recognition of moral distress and foster understanding of the AACN toolkit concepts. The poster provided a resource to guide group discussions using the 4 A's.

A group exercise was done to provide an interactive teaching component. Nurses were asked to complete the classroom exercises of moral distress situations and moral distress in the workplace that were included in the participant guide. After eliciting moral distress situations from the nurses' personal experiences, group discussions about their

experiences helped guide strategy developments about how to cope with the moral distress situations. The researcher utilized the 4 A's to help develop the strategies with the class. Building recognition of the concepts before the formal toolkit review reinforced retention of the behaviors that were learned.

Review of the power point slides was the next phase of the teaching project. The slides were adapted from the original power point slide presentation that came with the AACN toolkit. The slides, which were reviewed in depth, included the moral distress definition, AACN position statement on moral distress facts, nursing and environmental impacts resulting from these ethical decisions, and the AACN Rise Above Moral Distress concepts utilizing the 4 A's. Concept reinforcement and question and answers concluded the power point presentation.

The tool-kit provided several case studies. During the education session, a thorough review of one case study was analyzed. Participants were asked about their perceptions of the situation, initial actions, secondary actions, alternative actions, coping mechanisms, and resources to be utilized. Participants were able to ascertain what the situation means to them based on their individual values. Is the situation stressful, good, or not important? Those are some common responses. After the meaning was discussed, review of how they would classify the event occurred. Was it perceived as a threat, challenge, or not harmful. Additional case studies could be reviewed with the provided resources during independent study time.

After the case study, questions were answered and concerns addressed. Completion of the program evaluation survey was requested. Laminated cards were

handed out as a reference of the coping concepts to deal with ethical situations. Participants were reminded of the post-survey to be completed in two months. The survey for the post education was left in the nursing lounge for nurses to complete. After completion, the survey was deposited in a labeled sealed drop box.

Measurement

The pre and post-survey questions were developed by the researcher to measure baseline knowledge and knowledge retention two months post the education session (Appendix B). The two month time period was chosen to allow the nurses to have time and experience to utilize the information obtained in the educational session. Based on the literature review, some of the main issues with moral distress are the lack of awareness and understanding, lack of support resources, poor ethical environments, and ineffective coping skills. The survey questions were generated to collect data reflective of these main issues. The pre and post-survey used a Likert scale with a five point response format ranging from strongly agree to strongly disagree. The moral distress survey was composed of two parts. The first part was a 10 question Likert scale and the second was three open-ended questions. The Likert scale was intended to give an understanding of the present knowledge of the medical surgical nurse about moral distress in regards to the areas of definition and understanding, coping, available resources, AACN 4's, and the present work facility environment. The open-ended questions gave the individual an approach to better communicate their feelings and understanding of a moral distress situation.

Evaluation

A program evaluation survey developed by the researcher was given upon the conclusion of the teaching session to evaluate the effectiveness of the teaching.

Data analysis

Basic descriptive statistics was used to analyze the study data. The central tendency of mean average was used to obtain comparisons of the collected data. Significant differences between the pre and post-test scores were noted. Open-ended questions were analyzed for common themes

Next the results will be reviewed,

Results

The total number of participants was 18 for the pre-survey and 14 for the post survey. All participants in the educational intervention completed the pre-surveys. Figure 1 illustrates the age breakdown of the attendees.

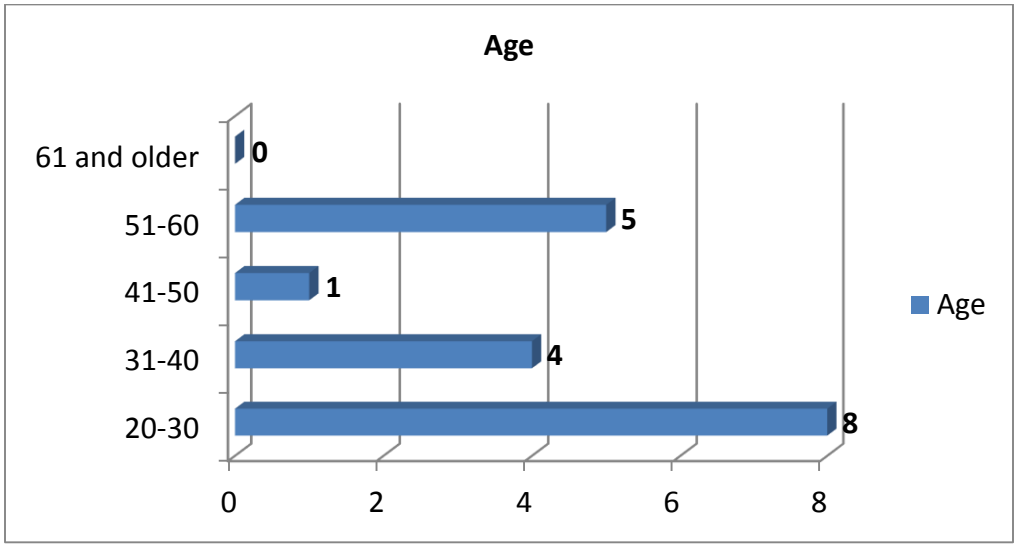

Figure 1. Age comparison of the sample

The majority of the participants were between the ages of 21-30, or 44% of the participant group. The next highest group was the 51-60 years of age (28%) followed by 22% for the 31-40 age group. None of the participants were greater than 61 years old. The vast majority of participants were female (n = 31; 97%).

Figure 2 on the next page illustrates the percentage of participants by shift.

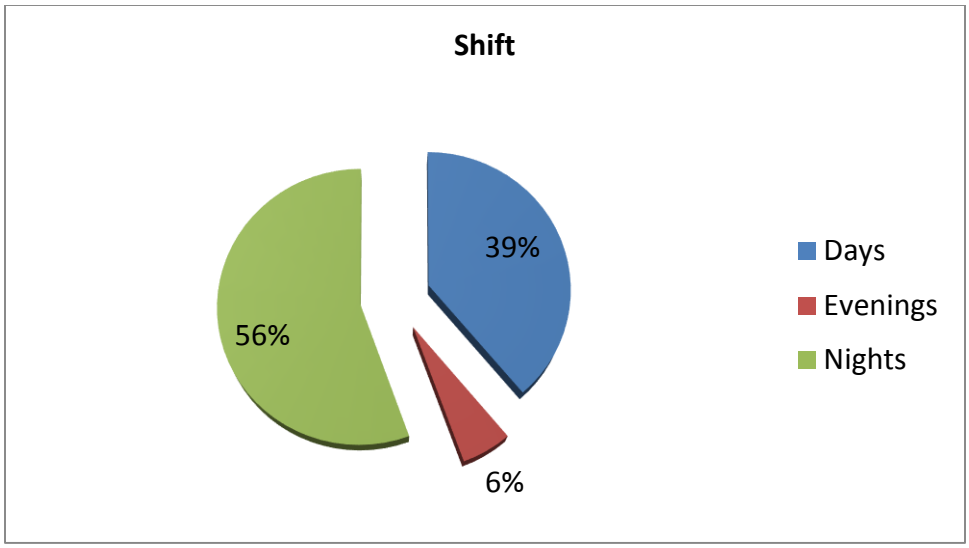

Figure 2. Shift comparison of the sample.

Nurses on the night shift completed the most surveys (n = 18; 56%) while nurses on the evening shift accounted for the fewest (n = 2; 6%).

Figure 3 shows the work experience of the participants.

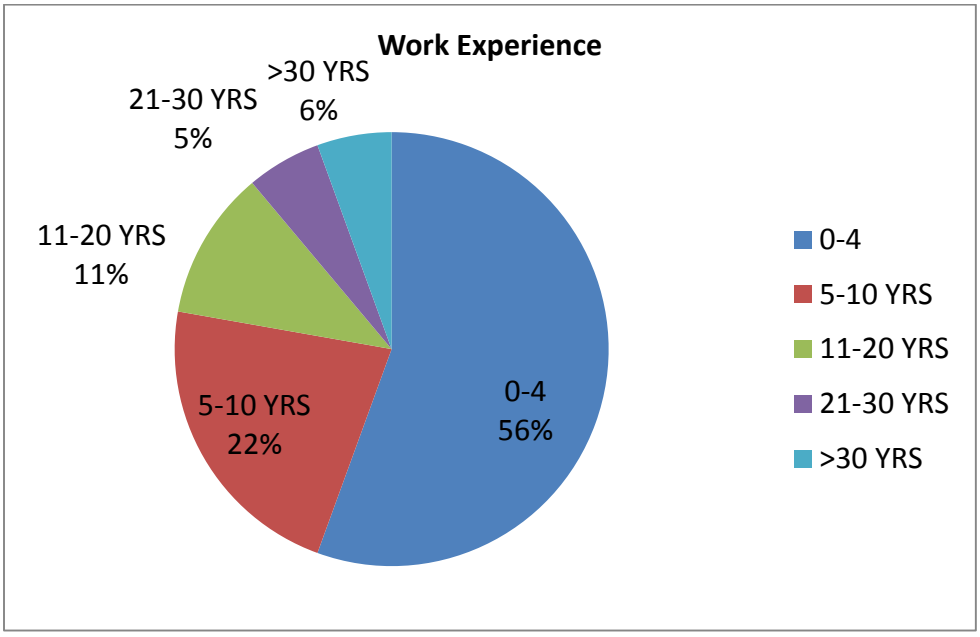

Figure 3. Work experience of the sample

Seventy eight percent (n = 14) of the participants had work experience between 0-10 years. Of the two categories, the majority of individuals who responded had worked for only 0-4 years, accounting for 56% (n = 10) of the survey data. In summary, results from the demographic data showed that the participants were female in the age group of 21-30 who worked nights and had work experience of less than five years.

The results of the pre and post survey will be reviewed next. The tables below show the results by questions in numbers and percentages. Table 3 illustrates the pre-survey responses.

Table 3

Pre-survey responses by category results and percentage

	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE OR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE
Question					
1	1=6%	2=11%	4=22%	8=44%	3=17%
2	1=6%	0=0%	1=6%	12=67%	4=22%
3	1=6%	2=11%	5=28%	6=33%	4=22%
4	1=6%	0=0%	4=22%	8=44%	5=28%
5	8=44%	4=22%	3=17%	1=6%	2=11%
6	1=6%	1=6%	4=22%	10=56%	2=11%
7	4=22%	5=28%	3=17%	4=22%	2=11%
8	1=6%	4=22%	5=28%	6=33%	2=11%
9	1=6%	7=39%	6=33%	2=11%	2=11%
10	2=11%	0=0%	5=28%	8=44%	3=17%

Post-survey responses are illustrated in Table 4.

Table 4

Post survey responses by category results and percentage

	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEITHER AGREE OR DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE
Question					
1	1=7%	2=14%	3=21%	5=36%	3=21%
2	1=7%	0=0%	1=7%	5=36%	7=50%
3	1=7%	1=7%	2=14%	5=36%	5=36%
4	1=7%	0=0%	2=14%	5=36%	6=43%
5	2=14%	2=14%	2=14%	6=43%	2=14%
6	1=7%	1=7%	2=14%	8=57%	2=14%
7	4=29%	5=36%	2=14%	2=14%	1=7%
8	1=7%	2=14%	4=29%	6=43%	1=7%
9	1=7%	6=43%	5=36%	1=7%	1=7%
10	2=14%	2=14%	4=29%	5=36%	1=7%

Next, detailed responses to the post-survey questions by question are illustrated, as well as a comparison to the pre-survey.

Figure 4 identifies the participants' knowledge of moral distress, the focus of question one of the survey.

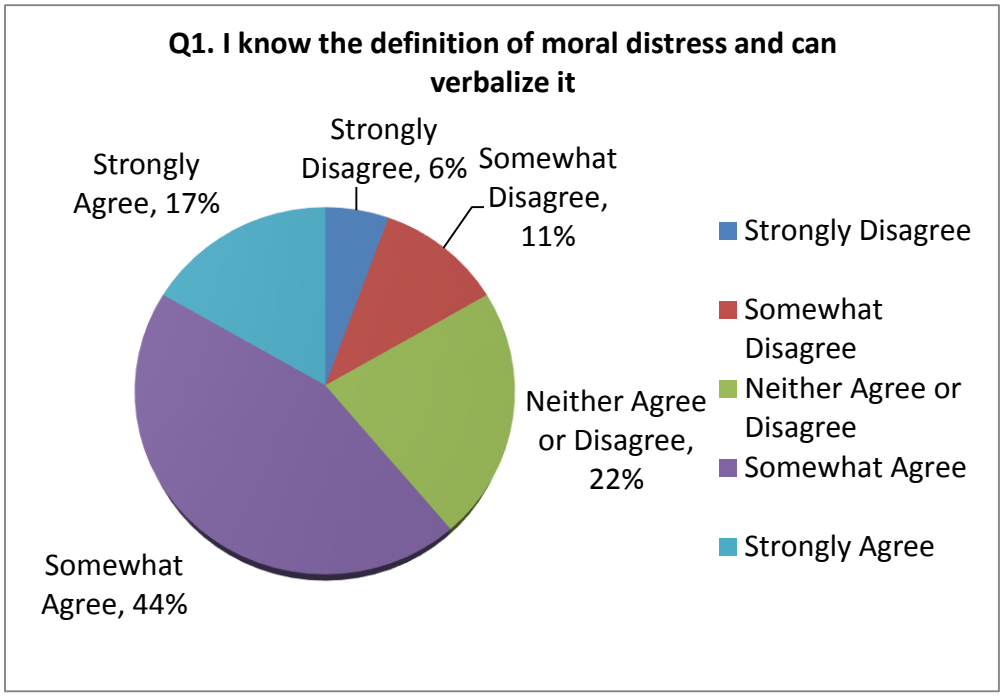

Figure 4. Knowledge of the moral distress

The majority of the nurses who completed the pre-survey believed that they knew the definition of moral distress and could verbalize it (n = 11; 61%). In the post-survey 57% responded that they knew the definition (n = 8).

Figure 5 illustrates the response to question 2: whether the participants could identify moral distress situations.

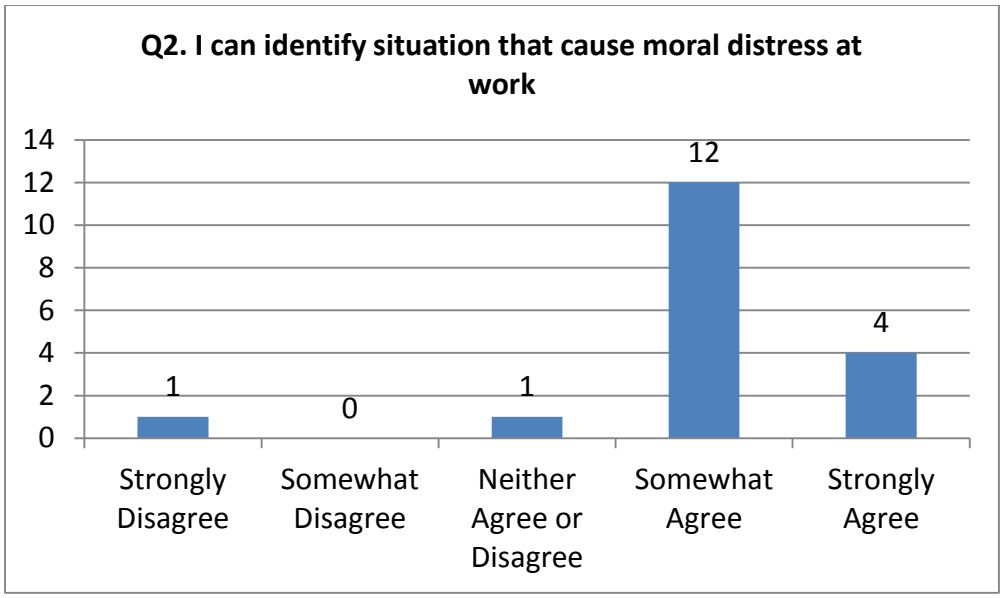

Figure 5. **Ability to identify a moral distress situation**

On the pre-survey, somewhat agree and strongly agree together dominated the results at 89% (n = 16). Somewhat agree and strongly agree on the post survey was the response for 86% of participants (n = 12). However, in the post survey there was an increase in the participants who strongly agreed (50%; n = 7) compared to the pre-survey (22%; n = 4).

The next two questions on the scale related to the participants' co-workers. The individuals were asked if they could be a support resource to the co-worker and if they could help a co-worker identify an ethical situation. The majority of the participants believed they would be able to support and help their co-workers: in regard to being a support resource, over half of the participants (55%; n = 10; pre-survey); (72%; n = 10; post survey) agreed that they could support a co-worker in a moral distress situation. Twenty-eight percent (n = 5) were undecided on the pre-survey as compared to 14% (n =

2) on the post-survey. Disagreement on the pre-survey was noted by 17% (n = 3) while in the post-survey it was 7% (n = 2).

Question 4 asked about helping a co-worker being able to identify an ethical situation. Seventy two percent (n = 13) in the pre-survey agreed that they could do this; the post survey showed a slight increase to 79% (n = 11).

Question 5 queried about knowledge of the AACN's 4 A's and position statement.

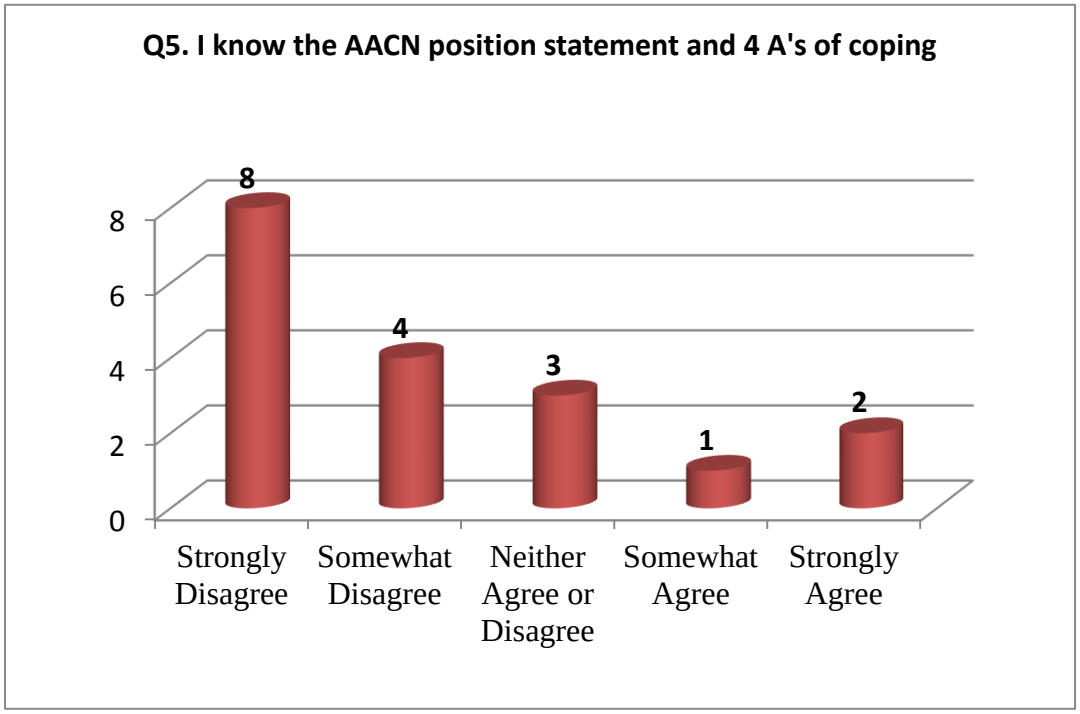

Figure 6. **Knowledge of the 4 A's and AACN position statement.**

Sixty six percent (n = 12) of participants disagreed on the initial survey. The post education survey showed a decline in disagreement (28%;n= 4). Agreement increased from 17% (n = 3) on the pre-survey to 57% (n = 8) on the post survey.

Question six addressed the individual's ability to cope effectively and minimize residual effects of moral distress. Although 22% (n = 4; pre-survey) and 14% (n = 2; post survey) were undecided in regard to this question, 67% (n = 12) of the pre-survey participants believed that they could cope effectively in moral distress situations. The post survey results increased to 71% (n = 10).

Figure 7 identifies whether the participants were educated on ethical situations.

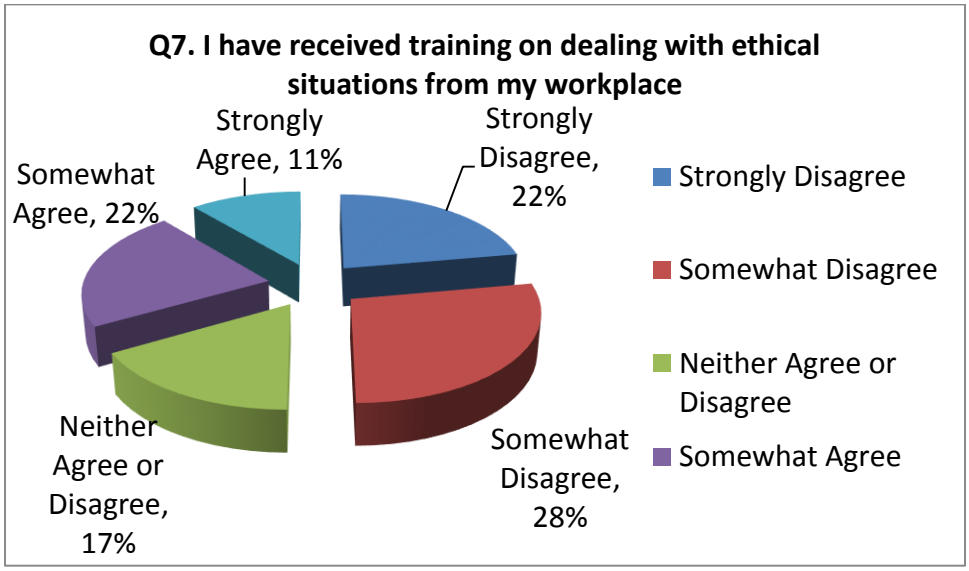

Figure 7. **Employees training on dealing with ethical situations.**

From the pre-survey, the majority disagreed with a total disagreement of 50% (22%; n = 4 strongly disagree and 28%; n = 5 somewhat disagree). Only 33% (n = 6) felt they had received the appropriate training, and 17% (n = 3) were undecided. The post

survey had a total disagreement of 65% (n = 9) and 21% (n = 3) in agreement with only 14% (n = 2) undecided.

Figure 8 identifies participants' belief about institutional support resources.

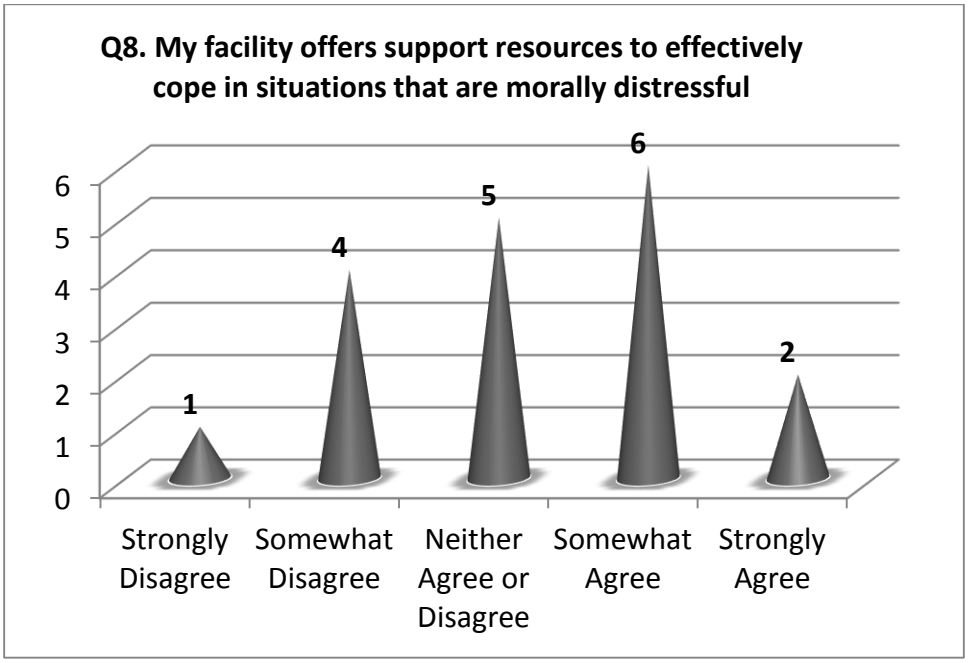

Figure 8. **Institution offers support resources for moral distress situations.**

Results of the pre-survey showed 44% (n = 8) agreed and 28% (n = 5) disagreed, but 28% (n = 5) of the sample was undecided. Post survey results illustrated that 50% (n = 7) agreed and 21% (n = 3) disagreed with this statement. Twenty-nine percent (n = 4) were undecided on the post survey.

The last two questions dealt mainly with the institution in which the participants worked. The hospital's support resources and ethical environment were the focus of the questions. Forty five percent (n = 8) disagreed that they knew the support resources, while 22% (n = 4) agreed that they could identify support resources and appropriate

individuals based on the pre-survey. Data from the post survey showed disagreement of 50% (n = 7), with 14% in agreement (n = 2) and 36% (n = 5) undecided. The last question of the survey asked if the facility provided a healthy ethical environment. The majority of participants agreed with this statement from the pre-survey (61%; n = 11). Twenty-eight percent (n = 5) were undecided. The post survey showed a decline in agreement to 43% (n = 6) with 29% (n = 4) undecided.

Participants were asked to complete three open-ended questions. Results were compiled and commonalities were ascertained. Participants were asked how they felt when they are experiencing moral distress. The common reaction responses included powerlessness, frustration, conflicted, stressed, overwhelmed, anxious, tearful, depressed, sadness, and wanting to quit. The participants identified several coping skills that they utilized during a moral distress situation: using the skills of debriefing; reflection; expressing concerns; open discussions; talking with co-workers; remaining calm; decompression; family; friends; exercise; prayer; and seeking help. The third open-ended questions asked the participants to name resources that were available in the institution to support them in ethical dilemmas. The supports resources identified were managers, charge nurse, social work, nurse educators, co-workers, case management, ethics committee, chaplain, collaborative care meetings, and Schwartz rounds.

A program evaluation was completed by the thirty-two participants. The participants strongly agreed that the environments used for teaching were conducive to learning and that the teaching materials were useful and appropriate (n = 30; 94%). Also,

most agreed (n = 28; 88%) that the content material was useful in their job. The participants strongly agreed (n = 31; 97%) that the time was adequate and the material was presented in an easy to understand manner.

Next, summary and conclusions will be presented.

Summary and Conclusions

Moral distress is a common but frequently overlooked concept in the nursing profession, though not exclusive to nursing. Many professionals experience this distress, but nurses encounter this phenomenon more often than other professions (Pauly et al., 2010). The concept of moral distress is difficult for an individual to grasp and most individuals do not realize what they are experiencing. When looking at moral distress from the prospective of the nurse, most nurses feel it is part of the job or that there is nothing that they can do about the situation (Maluwa et al., 2012). Moral distress can cause many physical and emotional symptoms that affect how a person perceives satisfaction in their profession. Depending on the situation and the frequency, nurses who experience moral distress are more likely to escalate to the point of burnout, the psychological conditions that results from ineffective coping strategies from stressful situations (Edward & Hercelinskyj, 2007).

Moral distress is an approved nursing diagnosis and was included in the 2007-2008 edition of *Nursing Diagnoses: Definitions and Classifications* (L.M. Scroggins, personal communication, April 1, 2006). The American Association of Critical-Care Nurses (AACN) also realized the importance of moral distress as a serious problem in nursing and developed its own definition and policy position. The AACN policy position acknowledges that moral distress is a critical, frequently ignored, problem in healthcare work environments. Moral distress inhibits job satisfaction and restricts nurses from providing optimal patient care when the phenomenon is not addressed. A healthy work

environment should be created to alleviate the harmful effects of moral distress. AACN goes further to recognize that program implementation to address the effects of moral distress is the responsibility of the nurse and employer (2004).

A comprehensive literature review clearly revealed the important determinants and the widespread impact that result from the experience of moral distress. The literature supported the need for education and organizational support to combat the effects of moral distress. This project targeted medical-surgical nurses and aimed to provide them with education to identify moral distress as well as appropriate coping skills that may be used to deal with the moral situation.

The project was reviewed by the IRB and determined to be a quality improvement project. Permission was granted from the hospital administration and the unit manager. Education sessions were coordinated with the nursing manager. The project design consisted of a pre-survey, an intervention, and post-survey. The theoretical frameworks of Watson and Lazarus were used to guide the project. The sample consisted of the medical surgical nurses on 4 West at the Miriam Hospital. Staff nurses were informed about the education program by flyers, reminders at staff meeting and collaborative rounds and by screensavers. The AACN Rise Above Moral Distress education plan, which uses the 4 A's of Ask, Affirm, Assess, and Act, was utilized for the five staff education sessions. The education sessions lasted 1 hour. The pre-surveys were administered and collected prior to the teaching. After completion of the program, participants completed a program evaluation survey that was created by the researcher and approved for use in the project. The surveys were placed in locked drop boxes. A

total of 18 pre-surveys and 14 post surveys were collected. The data was entered in Word Excel and analyzed using descriptive statistics with the central tendency of mean average.

The surveys consisted of demographic questions, information about moral distress via Likert scale and open-ended questions. The majority of respondents were females in the age group of 21-30 who worked nights and had work experience of less than five years. The majority of participants believed that they understood what moral distress was and could identify a moral distress situation. Additionally, the participants believed that they could be a support resource to a co-worker and help the co-worker identify potential ethical situation(s). The majority of the participants agreed that the hospital had support services and a healthy ethical environment. However, most participants did not know of the AACN position statement or the 4 A's based on the pre-survey results. The major difference between the pre and post survey was associated with this question. The percentage that disagreed with knowing the AACN position statement or the 4 A's changed from 66% (n = 12) in the pre-survey to 28% (n = 4) in the post-survey, and the participant's agreement with the statement changed from 17% (n = 3) to 57% (n = 8).

The post survey showed an increase in the nurses' confidence to identify a moral distress situation at work. The participants that strongly agreed with identifying a moral distress situation at work increased from 22% (n = 4) to 50% (n = 7) and the somewhat agree when from 67% (n = 12) to 36% (n = 5). Another area that showed an increase in the nurse's confidence after the teaching was with a nurse's ability to help a co-worker identify an ethical situation. There was an increase in the strongly agree percentage from

28% (n = 5) to 43% (n = 6) and the somewhat agree percentage went from 44% (n = 8) to 36% (n = 5). Nurses believed that they coped effectively, but formal training on coping skills has not been done. This was a consistent finding on both surveys.

Nurses from this unit indicated that they knew what moral distress was and that they coped effectively. Support systems could be identified but were under-utilized. The institution did not offer any formal training on moral distress. Nurses learned to cope from situation experience. Participants had confidence that they could help a co-worker deal with and identify ethical situations. The educational sessions increased the number of participants that knew the AACN position statement and the 4 A's to rise about moral distress. Improvements were also noted in the areas of co-worker support and ethical situation identification. The education sessions increased the nurse's confidence and ability to identify, cope, and support co-workers with moral distress. Based on the results of the survey questions, more ethical training and formal coping skills training is needed. The open-ended questions showed the participants could identify moral distress situations, name appropriate coping skills, and list the available support resources within the institution.

The program evaluation revealed that the participants strongly agreed that the environments used for teaching were conducive to learning and that the teaching materials were useful and appropriate. Also, most agreed that the content material was useful in their job. The participants strongly agreed that the time was adequate and the material was presented in an easy to understand manner. Recommendations for future

teaching sessions were different time schedules, CNA training, education classes in the break room or near the unit, and expansion to other units and specialties like case management, social work, and unit secretaries.

There were several limitations of the study. Ninety-four percent (n = 17) of the surveys were completed by females. The majority of the participants that completed the study were employed on the unit for 0-4 years and worked the night shift (56%; n =10). Nurses in the 0-4 year category may also perceive the survey as an obligation, since they are newer to the profession and the unit. Time was potentially an additional factor that limited the results. It was difficult for a nurse to take an hour out of his/her work shift, and many nurses were reluctant to come in on off shifts just for an hour education session. Survey saturation is another issue that impacts survey participation. Nurses become bombarded with surveys, and the drive to response to a survey diminishes. This project was completed on one medical-surgical unit, thus the diversity and complexity of other specialized units was not represented. Due to the limited sample size, the results are not indicative of the medical surgical nursing overall.

In conclusion, nurses on this unit knew about moral distress and could identify these situations. Furthermore, the participants stated they could be a resource for other nurses during a moral distress situation and help a co-worker identify an ethical situation. The participants did know some support resources but lack in the knowledge of how to access them. Resource identification and accessibility education for the staff could help with coping when dealing with moral distress. These nurses did not receive any formal

training on ethical situations or moral distress. Nurses learned to cope by experience, and formal training is indicated. Educational programs have been proven effective in critical care areas. Programs like the AACN 4 A's can help increase staff knowledge and confidence with ethical situations. Managerial support is essential to a successful educational program. All nursing staff and management should be included in the education sessions. The cost of the program education is negligible when compared to the physical and psychological impairments from moral distress. Research literature supports that a healthy ethical work environment promotes safety, quality, and employee happiness and satisfaction.

Recommendation and Implications

Several recommendations were identified. First, formal training sessions should be held to educate nursing professionals about moral distress and appropriate coping methods. Nurses develop coping skills by independent experiences derived from ethically challenging work situations. A uniform approach would help nurses to cope more effectively. On-going training with methods like the AACN 4 A's should be utilized for the education sessions. Once the appropriate training is in place for nursing personnel and desired outcomes are achieved, the education can be expanded to other health care professionals like social workers, case management, nursing assistants, and physicians. Moral distress is not exclusive to nursing, so education to all healthcare employees will help to provide a positive ethical environment with understanding of the resources that are available to assist an employee in a moral distress situation. Interdisciplinary, collaborative education would also facilitate health professionals to learn from each other in this challenging area. Institutional acceptance to combat the negative effects of moral distress is paramount to the development of a successful moral distress program. With administrative support, programs to create a healthy ethical environment can be adapted to account for cultural diversity and interdisciplinary work environments. This will help to enhance understanding and accessibility for all employees. Programs should be available with consideration taken for language barriers and the different ways that cultures learn to cope in ethical situations. A well rounded program with organizational compliance will gain acceptance from state and national associations.

Second, universal protocols need to be developed to help support health care workers. Such a protocol could help nurses to cope effectively with the moral distress situation and guide nurses to navigate within the institution and to access the needed support from available resources. The advanced practice nurse (APN) can be an integral part of the development of protocols to cope with moral distress, education of staff members, employee support, and on-going evaluation and monitoring of anticipated goals. The APN can advocate for mandatory competency training for new employees and provide on-going training for reinforcement. Benchmarking and evidence-based practices from successful moral distress programs should be utilized to foster institutional and legislative changes in healthcare policy for healthcare workers. Unit-based ethics conversations have been used in other institutions to directly provide support on the nursing units by promoting an open environment for discussing ethical concerns. Advance practice nurses have the ability to research established programs that have been successful in helping employees deal with moral distress. The APN could be an institutional representative and present innovative, evidence-based programming at national conferences to increase awareness and promote action within the healthcare community.

Research should be done with other specialties within nursing such as oncology, critical care, and orthopedics in order to formulate a more in-depth perception of moral distress in the nursing profession as a population. More globally, health care institutions' environment, culture, and resources should be studied and compared. The comparison

of national and international views would identify common themes and isolate cultural considerations for future moral distress programs.

Lastly, public policy implementation to reduce the adverse effects of moral distress needs to be developed. Moral distress has an impact on the quality and safety of care that the community receives. Poor patient outcomes are associated with poor ethical climates. Evidenced based practices and programs will improve outcomes and gain endorsement from local and national associations. National association acceptance will promote lobbying and changes on a legislative level.

Moral distress training is essential to any healthy work environment.

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Appendix A

Moral Distress Education Classes May 8th 2-3pm, 19th 6-7pm, 20th 5-6pm, and 28th 12-1pm

DON'T LET THIS STRESS IMPAIR YOUR PERSONAL OR PROFESSIONAL LIFE. LEARN TO IDENTIFY AND COPE IN ETHICAL SITUATIONS

- *Identifying Moral Distress*
- *Nursing Experiences*
- *Group Discussions*
- *AACN Position and 4 A's of coping*
- *Clinical Situation*
- *Review of Concepts*
- *Reference Materials*

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

Ask • Affirm • Assess • Act

The 4A's to

Rise Above Moral Distress

Appendix B

Pre and Post Survey

1. Please circle the appropriate demographic information and place this survey in a separate manila envelope than the moral distress survey

2. Age
    a. 20-30
    b. 31-40
    c. 41-50
    d. 51-60
    e. 61 and older

3. Gender
    a. Male
    b. Female

4. Shift
    a. Days
    b. Evenings
    c. Nights

5. Work Experience
    a. 0-4 year
    b. 5-10 years
    c. 11-20 years
    d. 21-30 years
    e. 30 years or more

	Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree
I know the definition of moral distress and can verbalize it.	⬡	⬡	⬡	⬡	⬡
I can identify situations that cause moral distress at work	⬡	⬡	⬡	⬡	⬡
I can be a support resource to help other nurses experiencing moral distress	⬡	⬡	⬡	⬡	⬡
I can help identify ethical situations to my nursing co-workers	⬡	⬡	⬡	⬡	⬡
I know the AACN position statement and 4 As of coping	⬡	⬡	⬡	⬡	⬡
I can cope effectively in moral distress situations and minimize residual effects	⬡	⬡	⬡	⬡	⬡
I have received training on dealing with ethical situations from my workplace	⬡	⬡	⬡	⬡	⬡
My facility offers support resources to effectively cope in situations that are morally distressful	⬡	⬡	⬡	⬡	⬡
I can identify the support resources and how to contact the appropriate individuals at my workplace	⬡	⬡	⬡	⬡	⬡
I work in a facility that provides an healthy ethical environment to openly express and deal with ethical situations	⬡	⬡	⬡	⬡	⬡

What coping skills do you utilize in a moral distress situation?

How do you feel when you are experiencing moral distress?

What resources are available in your institution to support the nurse in ethical dilemmas?

Appendix C

Program Evaluation

1. Was the environment conducive to teaching?

Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree

2. Were the teaching materials useful and appropriate?

Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree

3. Do you feel the content material will be useful in your job?

Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree

4. Was the material presented in an easy to understand manner?

Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree

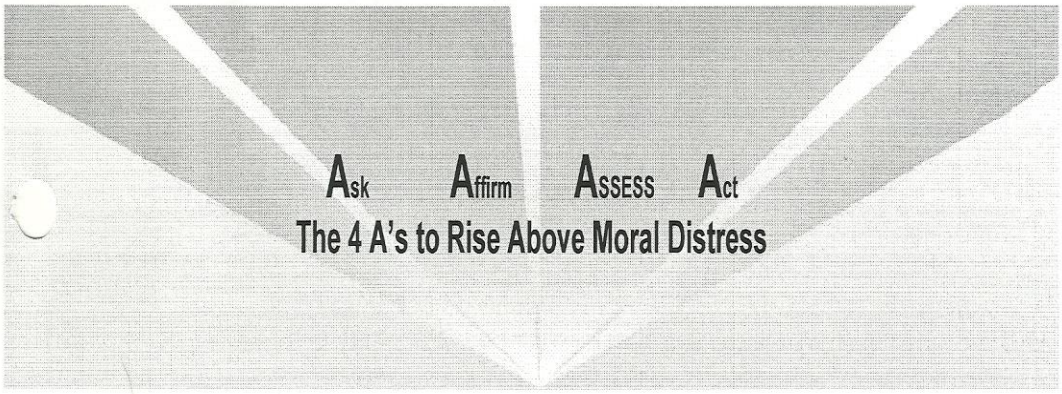
5. Did the time seem adequate for the material presented?

Strongly Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Strongly Agree

6. Do you have any recommendations for future teaching sessions?

7. Other comments or suggestions?

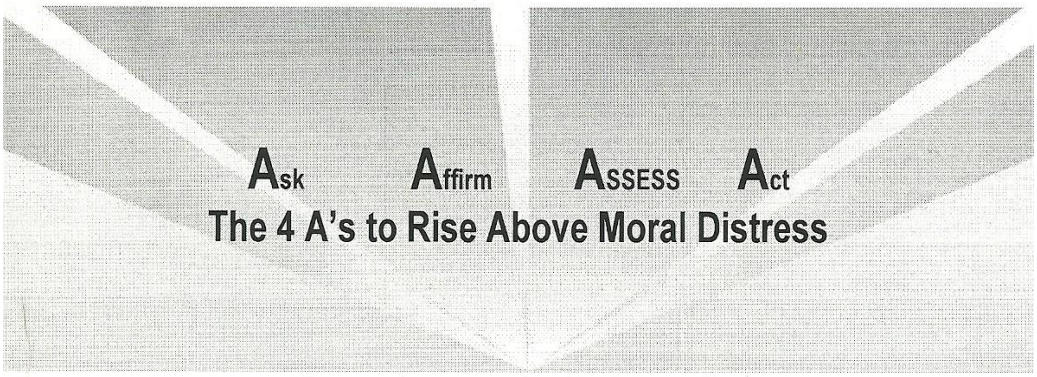
Appendix D



CLASSROOM EXERCISES

Describe a Situation When You Experienced Moral Distress.

- How did you respond to the situation at the time?
  - How did you feel?
  - What did staff/employees say to each other?
  - What did you say to patient/family?
  - Were you able to find help? From whom?
  - What did you want to do?
  - What did you do?



CLASSROOM EXERCISES

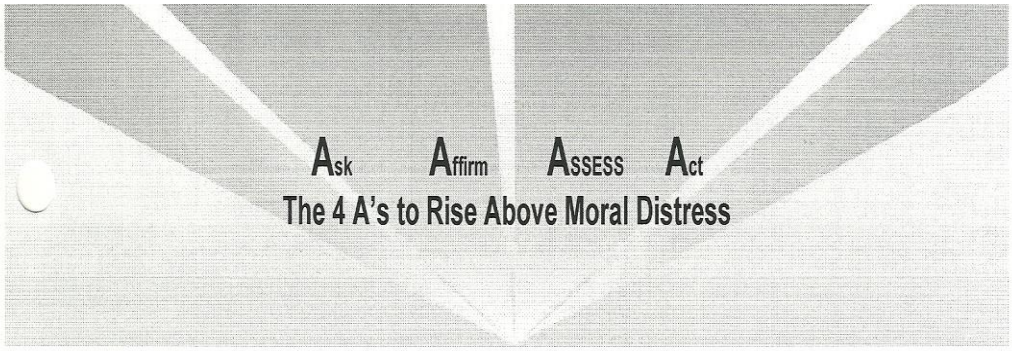
MORAL DISTRESS IN THE WORKPLACE

- What challenges/problems do you face that create moral distress for you?

- What causes these challenges or problems for you?

- What would help to alleviate your moral distress?

- What would you personally be willing to do to alleviate your moral distress?



CLASSROOM EXERCISES

CASE I

Administrative Case

Moral Distress: Insufficient Resources for Care

CASE

JR, an experienced nurse manager of a large medicine unit with 10 progressive care beds, has become uncomfortable with the challenge of providing resources and supporting staff to care for an increasing complex patient population. When the progressive care unit was established, it provided a higher level of care than the general medial surgical units, including telemetry, more frequent observations and assessments, and noninvasive monitoring—all of which generally was accomplished with 1 nurse to 4 or 5 patients. As her organization has experienced an increased demand for more complex care, a shortage of critical care beds and emergency department diversion increase the level of interventions and monitoring for these patients, with little to no adjustment in hours per patient day. Patients now receive vasoactive drugs and arterial lines and are often significantly compromised and require close monitoring. During the past several months, the situation has escalated because JR now reports to a new director who is focused on achieving financial and productivity targets and is not open to renegotiation of staffing numbers. JR has tried to provide the necessary information to her director but has been unsuccessful. While JR understands that the organization is financially troubled and that administrative staff have been terminated when unable to meet established targets, her confidence in the organization's leadership has been affected. The words in the organization's mission statement seem hollow.

JR had begun to supplement her staff using overtime dollars to get to a higher nurse to patient ratio but had been told to get her personnel costs back in line or she would suffer administrative consequences. In addition to experiencing a lack of support from her director in solving this issue, staff members have become increasingly unhappy and concerned about patient safety. Last night was the final straw for JR. A patient who had a cardiac arrest was kept on the unit because no beds were available in the ICU and 2 of the nurses working during that incident tendered their resignation, worsening the staffing deficiencies. Caught in the middle between the needs of the patient, nurses, and organization, JR was ready to give up a job she had always loved.