Examining the Human Experience of Moral Distress: A Narrative Inquiry

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Abstract

Background: Evidence suggests that one in three nurses will experience moral distress, which has been associated with intent to leave, depersonalization of the patient and disengagement with work at some point in their career.

Purpose: The purpose of this narrative inquiry was to identify nurses that have experienced a morally distressing experience in practice and give them the opportunity to share their lived experience and share the impact of their experience. This study provided a better understanding of the complexities of moral distress.

Method: Convenience sampling was used to select the female registered nurse participants. Narrative inquiry was used to collect the experiences of moral distress.

Results: Twelve nurses wrote narratives for this study. Two themes (the voices behind the experience and outcomes of moral distress) and five subthemes were identified. All the participants mentioned that *not being heard* and *silencing of self*, contributed to moral distress. Participants also discussed strategies for growth after a morally distressing incident.

Implications for practice: Nurses in many different settings have the potential to experience moral distress. This finding suggests that interventions for moral distress should be considered in any setting. This study also identified the potential to learn and grow from morally distressing experiences.

Conclusions: The impact of self-silencing and the practice of being dismissed should be further explored to truly identify stronger and more effective interventions.

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A nurse is working in the emergency department and assumes the care of a 72-year-old female. The patient has a history of Chronic Obstructive Pulmonary Disease (COPD) and is having difficulty breathing. Through 2-3-word sentences, she confirms the Do-Not-Resuscitate (DNR)/ Do-Not-Intubate (DNI) that was brought in with her on the ambulance. The nurse and doctor agree with her decision and discuss supportive measures. The severity of her condition is discussed with the patient and she agrees that she is "ready to go". As the nurse provides comfort measures, the mentation of the patient begins to deteriorate along with her vital signs. The patient's daughter arrives after the patient loses consciousness. The doctor and nurse discuss her mother's condition and confirm the mother's decision to be a DNR/DNI. The tearful daughter states "that is not what my mother wants, she was not oriented enough to confirm that. I want everything done". After minutes of discussion, the patient's heart monitor alarms that her heart rate has slowed and is no longer compatible with life. As her rhythm turns to asystole, the daughter demands everything must be done. A code blue is called, and as staff enter the room the nurse begins chest compressions and the doctor prepares to intubate.

On the medical-surgical floor upstairs, a 42-year-old male recovering from a small bowel obstruction is writhing in pain. For the past 12 hours, he has had 9/10 sharp pain in his abdomen. The nurse coming on shift does a quick assessment and identifies that his abdomen is hard, the patient is holding his stomach, and his heart rate is elevated while his blood pressure is lowering. In pass down, the off-going nurse mentioned that the patient was complaining of pain all night, but she did not give him any medication due to fear of constipation. She mentioned he would complain of pain, but then would fall asleep. "The patient is just overly dramatic" the nurse explained as she completed her pass down. She mentioned she left a message for the doctor two hours ago but had not seen or heard back. The oncoming nurse is concerned that the patient has

perforated his bowel. The nurse pages the physician again after not being able to reach him on his phone. After waiting 10 minutes, the physician calls back and the nurse relays her assessment to the physician. She verbalizes that she is concerned that the patient may have a perforation. The physician responds by ordering 2mg of morphine IV and states that he will be rounding shortly and will re-assess him. The nurse goes to administer the medication, but now the blood pressure has significantly dropped lower and is too low to administer the medication. The patient is now confused and becoming pale. The nurse calls the physician again, with no answer. After minutes of waiting, the nurse knowing this is a potentially critical situation decides to call the Rapid Response Team (RRT) to assess the patient. Upon arrival of the team, the attending physician shows up and berates the nurse for calling a RRT when he was just a few rooms over.

These scenarios are only a few of the many experiences that may cause distress among nurses. Going against a patient's wishes or working with incompetent health care providers may lead to frustration, guilt, and powerlessness. These feelings occur due to the inability "to practice according to their ethical standards" and is termed moral distress (Henrich, Dodek, Gladstone, Alden, Keenan, Reynolds, & Rodney, 2017, p. 49).

Moral distress was first identified as a situation 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). The American Nurses' Association (ANA) later went on to state that moral distress threatens the core values and moral integrity of the nurse (ANA, 2015). While there are many definitions to conceptualize moral distress, for this paper it will be defined as the psychological and emotional toll that occurs when a nurse acts in a way that conflicts with their personal ethical values (McCarthy, 2013). In 2009, Epstein and Hamric identified the top 21

situations that may lead to moral distress among registered nurses (RN). These scenarios were used to create the Moral Distress Scale Revised (MDS-R) (Table 1) (Epstein & Hamric, 2009). The original scale can be found in Appendix A.

Table 1

Top 21 Moral Distress Scenarios

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

To date, research on moral distress has focused on investigating moral distress through quantitative research using the Moral Distress Scale- Revised (MDS-R) (Epstein & Hamric, 2009). While the frequency and intensity of each experience can be quantified, the personal experience of the nurse has been silenced and dismissed.

Statement of Problem

In the United States, researchers have estimated that there will be a shortage of 154,018 RNs by 2020 and 510,394 RNs by 2030 (Zhang, Tai, Pforsich, & Lin, 2018). Nursing turnover and the intent to leave are factors in the nursing shortage crisis. High stress levels among nurses has been linked to an increased intent to leave nursing practice. (Rushton, Batcheller, Schroeder, & Donohue, 2015). The ANA surveyed 4,614 nurses and identified that 74% of respondents were concerned with the acute or chronic effects of stress and being overworked (ANA Health & Safety Survey, 2011). Newer nurses reported higher levels of stress within the first year of practice and 25% left their position (NCSBN, 2018). Moral distress is a factor which has been correlated with professional stress (Borhani, Abbaszadeh, Nakhaee, & Roshanzadeh, 2014) and intent to leave (Millette, 1994). Evidence suggests that one in three nurses will experience moral distress at some point in their career (Redman, 2000). The role that moral distress plays in the nurse's intent to leave needs to be further explored to better understand the impact and potential interventions needed.

Previous studies examining moral distress do not focus on the effects on individual nurses, instead they have focused on the resulting decreased quality of patient care and increased health care costs. While morally distressing experiences can lead to the nurse's disengagement at work and depersonalization of the patient (Urden, Stacy, & Lough, 2018; Rathert, May, & Chung,

2016), the focus on patient and health care systems silence and dismiss the experience of the nurse.

For nurses to act against moral distress, they must be supported (ANA, 2015). In a phenomenological qualitative study of moral distress among emergency department nurses, the emotional toll of moral distress was evident (Robinson & Stinson, 2016). One respondent shared, "Nobody's there to talk to. We become different people and we become different nurses" (Robinson & Stinson, 2016, p.238).

The use of "counter stories" in nursing may help repair damaged moral identities by allowing nurses to share their work as knowledgeable and trustworthy professionals (Peter & Liaschenko, 2013). Counter storytelling is a powerful tool that supports voice in a group that is systemically silenced. Gathering and sharing stories helps to reveal that an individual is not alone, and others may share similar experiences (Delgado & Stefanic, 2001). Through sharing stories, nurses may shed light on the complexities of caring.

The aim of this study was to examine narratives of moral distress written by female nurses working in acute care hospitals in order to explore the impact this phenomenon has on the individual.

Theoretical Framework

The phenomenon of moral distress will be examined through the theoretical framework of oppressed group behavior (OGB). The Oppression Model has been used to examine the colonization of Africans, Latin Americans, Jews, and women (Roberts, 1983). "All of these groups can be said to be oppressed because they have been controlled by forces outside themselves that had greater prestige, power, and status and that exploited the less powerful

group" (Roberts, 1983, p. 21). The idealized "characteristics of nurses, i.e., warmth, nurturance, and sensitivity, have been viewed as negative when compared to the dominant culture, i.e., intelligence, decisiveness, and lack of emotion" (Roberts, 1983, p. 27). While nurses have made a tremendous effort to improve the public image of their profession, negative nursing stereotypes persist (Karanikola, 2011).

Nursing, which is often perceived as women's work, has been linked to the historical and social construction of women. As a result, nursing's status is often devalued (Brennan, 2005). This leads to power differentials which impede nurses' ability to express knowledge, both among themselves and to other health care professionals (Grinspun, 2011). Additionally, there is a power imbalance that occurs in the nurse-physician relationship which has been perpetuated by the hierarchy of the medical system (Grinspun, 2011). In one study, Grinspun (2011) shared examples of witnessing a nurse justify her patient's wishes three times to the physician before an order was changed. The patient praised the physician for the order change when it was the nurse who had advocated for the change. The nurse's advocacy became invisible, and her voice was silenced (Grinspun, 2011).

Within the hierarchical medical system, there are many other examples of situations where the nurse's voice may be silenced or ignored (Fricker, 2013). Silencing the self, a component of OGB, occurs when nurses remain "silent about their own contributions to patient care, and therefore diminish their own sense of value, as well as their ability to deliver good care" (Roberts, Demarco, & Griffin, 2009, p. 290). Loss of self-esteem and depression are attributed to this type of silencing (Demarco, Roberts, & Chandler, 2005). Delgado and Stefanic (2001) stated that the cure for silencing occurs through sharing stories of individuals who suffer in silence.

Literature Review

In this section, literature related to the concepts which were explored in this study, will be discussed. These concepts are: silencing of self, moral distress, and growth and resiliency. The literature review is not meant to be a comprehensive review of the literature on these topics but is intended to give some background.

Silencing of Self

Women may not let others know what they need or feel, as a result of learned silencing behaviors (Demarco et al., 2005). According to Jack and Ali (2010), there are cultural forces that may contribute to women's self-silencing in public settings. One force is the belief that a woman's body is passive. The notion that a "woman should be seen and not heard" implies that being a woman makes one less intelligent than a man (Jack & Ali, 2010). This belief may lead to a focus being placed on looks and perpetuate the notion of the need for women to be careful in what they say (Jack & Ali, 2010). Another force is the expectation that women will be nice. "The fact that men hold more power in society contributes to this interest in developing and maintaining non-contentious relationships" (Jack & Ali, 2010, p. 141). This may be evident in the traditional hierarchical structure of the medical field where nurses (traditionally women) were primarily seen as a subservient to the physician (traditionally men). While more men are entering the nursing field and more women are becoming physicians, some of the traditional power differentials may still be present.

Provision 5.3 of the ANA's Code of Ethics, states that "Authentic expression of one's own moral point of view is a duty to self" (p. 20). A respectful and "open-exchange of views" is necessary to support nurses and support a voice that is integral to the care of the patient and

healthcare team. Provision 5.4 states that when nurses "are placed in circumstances that exceed moral limits or that violate moral standards in any nursing practice setting they must express to the appropriate authority their conscientious objection to participating in these situations" (ANA, 2015). When a nurse engages in self-silencing, they may not be able to communicate their conscientious objection. This inability may lead to experiences of moral distress

Moral Distress

Moral distress has been identified among all healthcare disciplines, however, nurses and those that provide direct care at the bedside have an increased incidence of reported moral distress (Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). Moral Distress has been positively correlated with the intention of the nurse to resign ($r=0.229$; $p= 0.01$) (Papathanassoglou et al 2012). The severity of the experience ($r=0.244$; $p<0.0001$) and the frequency of the experience ($r = -0.209$, $P < 0.0001$) were also associated with the intention of resignation (Karanikola et al., 2014). Choe, Kang & Park (2015) identified five main themes of moral distress as: (a) ambivalence towards treatment and care (notably prioritizing work tasks over human dignity, unnecessary medical treatments and the compulsory application of restraints); (b) suffering resulting from a lack of ethical sensitivity; (c) dilemmas resulting from nurses' limited autonomy in treatments; (d) conflicts with physicians; and (e) conflicts with institutional policy.

As research has examined moral distress over the last three decades, other phenomena resulting from moral distress have been identified. Moral residue is the emotional residue left behind after a morally distressing event has resolved (Epstein & Hamric, 2009). Moral residue is defined as the "the lingering feelings after a morally problematic' situation has passed" (Epstein & Hamric, 2009, p. 332). A loss of moral integrity may result due to the person feeling they

have been compromised (Epstein & Hamric, 2009). With each morally distressing event and subsequent moral residue, the individual is at risk for experiencing moral distress more frequently, resulting in a stronger emotional response. This phenomenon is known as the crescendo effect (Epstein & Hamric, 2009). Due to the remaining moral residue, the clinician's moral distress baseline increases, never fully returning to pre-distress levels (Epstein & Hamric, 2009).

Growth and Resiliency

While moral distress, moral residue, and the subsequent crescendo effect threatens the psychological needs of the RN, there is a potential for growth and resiliency. Moral efficacy and moral courage may develop after a distressing event has occurred. Bandura's Social Cognitive Theory states:

> Human functioning is a product of the interplay of intrapersonal influences, the behavior individuals engage in, and the environmental forces that impinge upon them. Because intrapersonal influences, in which self-efficacy is a constituent, are part of the determining conditions in this dynamic interplay, people have a hand in shaping events and the course their lives take. (Bandura, 2012, p. 11)

Furthermore, Social Cognitive Theory

> addresses the growing primacy of the symbolic environment and the expanded opportunities it affords people to exercise greater influence in how they communicate, educate themselves, carry out their work, relate to each other, and conduct their business and daily affairs. (Bandura, 2012, p. 12)

According to social cognitive theory, the concept of self-efficacy is the foundation for moral-efficacy. Self-efficacy "is malleable; that is, through appropriate guidance individuals can increase their levels of self-efficacy" (Rathert, May, & Chung, 2016, p. 41). Self-efficacy, or an individual's belief that they have agency, is developed in the following four ways. The first way is through mastery experiences, which allow an individual to develop resiliency by overcoming obstacles, persevering, and learning from failure (Bandura, 2012). The second way is through social modeling. Social modeling happens when the individual finds similar individuals and is motivated by seeing them persevere. Seeing others' success, provides confidence that the individual may also find a way to be successful as well (Bandura, 2012). Social persuasion is the third influencer of self-efficacy. If the person is supported to believe in themselves, perseverance in the face of difficulty is increased. Emphasis is placed more on self-growth and less among competition between others (Bandura, 2012). The final influencer involves the monitoring of emotional and physical states. Reducing depression and anxiety, along with building up physical strength and stamina, increases an individual's self-efficacy (Bandura, 2012). Rathert et al. (2016) suggested that working on these four areas may impact how the nurse experiences and responds to moral distress. Supporting the nurse's self-efficacy may also support the development and strength of voice, a key component of moral courage (Rathert et al., 2016). Voice represents the "voice of agency, to act with courage, conviction, and capacity" (Rathert et al., 2016, p. 42).

Method

This study used narrative inquiry to explore the impact of moral distress on nurses working in acute care hospitals. The COREQ checklist was used to ensure the quality of the research report (Tong, Sainsbury, & Craig, 2007).

Methodology

Narrative methodology can be used to explore how an individual experiences and interprets the world around them (Joyce, 2015). Narrative inquiry provides access to people and their settings through their own stories and allows researchers to examine the meanings behind the words used to tell those stories (Wang & Geale, 2015). The focus of research using narrative inquiry is the individual's perspective of what happened (Wang & Geale, 2015).

While there are many narrative approaches, the life incidents approach was used for this study. Life incidents research "relates to human experiences and events that affect an individual's life" (Joyce, 2015, p. 38). Life incidents describe turning points in an individual's life and may present or differ in levels of significance. Personal meaning regarding the incident occurs retrospectively (Joyce, 2015). The narrative the participant shares is their version of events, related in a way that is meaningful to the story-teller. The participant's perspective impacts how their story is shared (Lewis, 2019). Through narrative inquiry, the researcher examines not just the story, but looks at the "why" behind the story the participant chose to tell, and examines how they shared the story (Lewis, 2019).

Data Collection

Convenience sampling was used to recruit participants for this study. Using private messenger on the Facebook app, a message was sent to 87 registered nurses the researcher has worked with, either in the past or present, describing the study and asking for volunteers to take part in the study. The University of Washington Tacoma also emailed a recruitment letter through their Alumni Association list serve (see Appendix B).

Recruiting occurred in the fall of 2018 following IRB approval by the University of Washington. Inclusion criteria for the study were: female, registered nurse, at least one year of experience in an acute care hospital, and currently employed in a full-time employee (FTE) position in an acute care setting. Female nurses were chosen because within the theory of OGB, self-silencing and the female gender have been strongly linked (DeMarco, Roberts, Norris, & McCurry, 2007).

Data collection and preliminary data analysis were concurrent. Recruitment ended when data saturation was achieved. Data saturation was accomplished when responses yielded redundant information (Moser & Korstjens, 2018).

The initial recruitment phase resulted in three interested participants from the Alumni Association and 33 through social media recruiting. An appointment was set up via phone or in person to discuss the study and screen for eligibility. The discussion included the activities required of participants, time requirements, and the purpose of the study. After the initial meeting, two nurses from the Alumni Association and 30 from social media agreed to participate in the study. Three of the recruits who had expressed interest stated they could no longer participate since they no longer worked at the bedside. Two of those individuals stated that moral distress was the reason they left the bedside.

The 32 nurses who agreed to participate were emailed a consent form to sign. Participants were given the opportunity to review the consent form and ask questions via a phone call or through email before signing. Reminders were sent out every two weeks to those expressing interest in the study, but who had not returned their consents. When recruitment ended in December of 2018, 12 consent forms were signed and returned out of the 32 that were provided in person or electronically.

After consent forms were signed, each participant was sent instructions for completing their narrative. Participants were also asked to complete a brief demographic survey. The 21 scenarios that comprise the MDS-R (Appendix A) were used as prompts for the nurses' narratives. Participants were asked to choose one scenario to think about while responding to six prompts (Table 2). The purpose of the prompts was to ensure that participants discussed how a morally distressing situation impacted them.

Table 2 Moral Distress Prompts

Prompt #	The Prompt
1	Describe the situation that led to your experience of moral distress
2	What about that situation was distressing?
3	When this situation happened, what did you feel physically, mentally, and emotionally?
4	When you recall this situation, what are your current feelings?
5	How has this experience impacted your nursing practice and or job?
6	How has this experience impacted your personal life?

Participants could write as much or as little as they desired. They were given the option to type their responses or write out their responses, and all responders chose to type their narratives. Due to the potential for distress as a result of the activity, phone numbers of counselors were provided to each participant. Participants were also informed they had the option to stop their participation at any point.

Participants were given three weeks to complete the study, and weekly reminders were sent to those who returned a consent but did not return a narrative. A total of 16 consent forms were returned, but only 12 narratives were completed.

Reflexivity

The primary researcher also served as the primary data collector and analyzer for this study. At the time of the study, the primary researcher was a doctoral candidate at the University of Washington Tacoma, a tenured nursing instructor at a different college, and a per diem registered nurse in the post anesthesia care unit (PACU). As a result of more than 12 years of nursing experience in acute care areas including: the emergency department, cardiac catheterization lab, and the PACU, the researcher has personally experienced moral distress and the emotional impact ethical dilemmas at work had on her personal life. After witnessing the emotional impact of moral distress on both colleagues and on herself, she was interested in exploring the qualitative components of moral distress through an individual's story. The researcher was also intrigued by the similarities and differences in these experiences. While aware of the complexities of nursing and the emotional impact that moral distress may cause, the researcher consciously separated her experiences while reviewing the narratives by focusing on the theoretical framework of OGB to guide the thematic analysis.

Data Analysis

Following the collection of narratives, any names or identifying details were changed on the transcriptions. Each response was assigned a number (P1-P12) to maintain anonymity. Data was coded by the author using the qualitative software program Quirkos (Quirkos, 2018), and results were checked by a faculty advisor who did not view the original transcripts.

Theoretical thematic analysis and inductive analyses methods were used to examine the responses to each prompt. Theoretical thematic analysis tends "to be driven by the researcher's theoretical or analytic interest in the area and is thus more explicitly analyst-driven" (Braun & Clarke, 2006, p. 84). Inductive analyses is […] "a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions" (Braun & Clarke, 2006, p. 83). Theoretical thematic analysis was used to identify the "surface meanings" of the narratives, while inductive analysis was used to examine "the underlying ideas, assumptions, and conceptualizations" (Braun & Clarke, 2006, p. 84). Specifically, theoretical thematical analysis was used to identify themes that pertained to the inability to be heard and/or silencing of self a component of the Oppressed Group Behavior theory. Then inductive analysis was used to identify additional themes that emerged during the analysis of each prompt.

Results

Description of the Sample

There were 12 participants, 10 were from the Puget Sound region of Washington State, one was from the east coast of the United States, and one was residing in Europe at the time of the study. Eleven of the 12 nurses answered the demographic questions. Ages of the respondents ranged from 28 to 54 years (mean= 37.9 years). Ten of the respondents identified as Caucasian, one identified as a Caucasian and Native American, and one identified as Caucasian and Filipina. Levels of nursing education of participants ranged from Associates Degree in Nursing (ADN) to Doctorate of Nursing Practice (DNP). The educational break down included: three ADNs, three Bachelor of Science in Nursing (BSN), one Master's of Nursing, and one DNP. Four of the respondents indicated they were currently in school working on a higher degree. Years of nursing experience ranged from one year to 28 years of experience (mean= 9.68 years of

experience). Four respondents had five years or less of experience as an RN in an acute care setting, four respondents had six to 15 years of experience, and two had more than 18 years of experience.

Participants were not asked to identify the unit the incident occurred on or where they currently work. This was done to protect the anonymity of participants. While the question was not asked, 11 participants mentioned the unit on which their experience occurred. Two respondents stated their experience occurred on a medical-surgical floor, two identified labor and delivery, three identified the emergency department, one identified the operating room, one identified mental health/jail, and two identified the intensive care unit. One did not identify the location of the experience.

In the 12 narratives, the word count ranged from 353 to 1,589 words per narrative (mean= 938.9 words per narrative). Using Quirkos software, a word cloud was developed to identify the most commonly occurring words, please see Appendix C. Two main themes were identified: *The voices behind the experience* and *Outcomes of Moral Distress.* The former was identified using Oppressed Group Behavior for the theoretical analysis, the latter using inductive analysis. Each main theme was comprised of several subthemes (See Table 3).

Table 3

Themes and Subthemes

Theme	Analytic Method	Subtheme
The voices behind the experience	Theoretic	Not being heard/dismissed Silencing of self
Outcomes of moral distress	Inductive	Emotional repercussions Physical symptoms Career implications *Intent to leave* *Growth* *Inability to provide the best care possible*

The Voices Behind the Experience

Before discussing the experiences of moral distress, it is important to first explore the situations that were written about. Of the 12 participants: three wrote about incompetent staff, four wrote about providing sub-optimal patient care, and five wrote about conflict. The common thread in these narratives was not *being heard*. Whether the participant did not feel heard as a result of self-silencing, from being dismissed, or from witnessing another nurse self-silencing; the narratives all discussed the role that not being heard has within the experience of moral distress.

Not Being Heard/Dismissed

In this sub-theme, participants discussed issues with not being heard. One participant (P1) shared her experience with a physician that dismissed her concerns. The nurse was concerned by what she perceived as the continuous deterioration of the patient's status. However, the physician dismissed her assessment of the situation. The participant shared, "I felt concerned for her, but the physician made me feel like it was not important and pressured me into this belief as

well." (P1). Later in her narrative, the participant shared, "I felt excited that I had caught something and that we could get more tests done, and then I instantly felt deflated at the shut down from the provider." (P1). The participant recounted that the patient continued to deteriorate and passed away a few days later.

Another participant (P6) shared an experience that occurred in the operating room. The surgeon dropped a sterile instrument on the floor and picked it up to reuse. After the nurse stated it was no longer sterile and that she could put it in the immediate use sterilization machine, the physician refused, cleaned it with iodine, and proceeded with the surgery using the unsterilized instrument. The operating room nurse reflected upon her experience and wrote, "I was standing up to a physician who was doing something blatantly wrong, and my voice had no volume" (P6). She went on to say: "I felt bad that the patient was there, trusting us, when her kindly surgeon did something like that. I was shocked that the event occurred at all" (P6). She also wrote, "I felt powerless because even though I stood up, my voice was not heard on any front. Nursing school taught me that I am a professional, but when push comes to shove, I am the help" (P6).

A third participant (P10) shared her experience working with a physician who did not answer his calls. The participant shared that she had a patient with respiratory distress that had arrived in stable condition but was quickly beginning to deteriorate. The participant made multiple attempts to contact the admitting physician. When the physician did not respond, the nurse found another physician willing to write orders for a CT scan. Upon arrival to the CT scan, the patient's heart stopped. A code blue was called overhead as CPR was initiated. The admitting physician showed up and took over the code. The family was brought into the room, and after unsuccessful rounds of CPR, the family told the staff to stop and the patient was declared dead. The participant shared in her narrative, "the physician approached me and said,

'are we okay with what happened?' I was too shocked as to what had happened to immediately respond or speak up and disagree with him" (P10). Her further responses revealed she was upset because her original concerns had been dismissed. As she said, "if I would have spoke [sic] up to the doctor and told him I thought he was not there when I needed him, he would have made excuses" (P10). While this participant initially chose voice, when she was not heard, she self-silenced.

During a situation where tensions were high, P12 shared a story of a physician yelling at the nurses,

> The fact that as nurses, all we were trying to do was what was best for our patient. The doctor came to the situation and acted as if we were intentionally trying to cause harm. Instead of reacting the way he did, by yelling at us and accusing us, he could expressed [sic] his concerns more appropriately (P12).

She shared that she felt the following emotions during this experience,

> Mentally I was trying to process the situation and still participate in helping in the code. I was also confused. I felt upset because the doctor acted so. I felt offended. I also felt very badly for my charge (P12).

Silencing of Self

The theme of silencing of self-involved instances where participants felt they could not express themselves. P12 said that after the physician yelled at her and the other nurses, she felt the only thing she could do was, to keep quiet, even though she wanted to say the following:

> I wanted to so badly defend my charge nurse to the doctor directly. I wanted to tell him what else would he have expected us to do. We were working within the parameters of what we know and what we are expected to do (P12).

Another participant (P8) shared an instance where she witnessed self-silencing occur during the care of a young infant in a teaching hospital. She recounted that a painful and invasive diagnostic procedure was ordered on this infant. As the parents waited outside the room, multiple residents, and the attending physician, unsuccessfully attempted the procedure. When the parents were allowed back into the room, they saw their infant covered in bandages. The participant wrote that she was concerned with the fact that the "nurses involved in this case did not speak up and tell medical staff to stop" (P8), and "I had a difficult time understanding why nurses felt they could not advocate for the patient" (P8). She went on to write, "the staff was visibly upset and voiced their concern about the situation, but ultimately they felt they could not do anything about it due to the ranking system" (P8). This participant wrote that she continues to feel dismissed and voiceless, even though she is now in a management position:

> Sometimes I wonder why I went back to school to get my MN in nursing education/leadership. At this point in my career I feel I wasted my money because the leadership/education positions here do not account for much. There is always someone who outranks you and calls the shots; policies do not change, and the care here does not align with standards. There is no advantage to taking a leadership/education position at this facility (P8).

Another participant (P1) shared multiple examples of events she had experienced where she felt she could not speak out. Some experiences involved working with incompetent staff and witnessing patients suffer because of that. When writing about what upset her the most about these experiences, she shared, "if I could only be a better advocate." (P1). In the theme of self-silencing, participants were most concerned about the effect that not speaking up had on their

patients. As another participant said, “I wonder if I had said something differently/more effectively it could have changed the outcome” (P5).

Outcomes of Moral Distress

The second major theme identified was *outcomes of moral distress*. Subthemes identified were *emotional repercussions, physical symptoms,* and *career implications*. While career implications included the intent to leave and the inability to provide the best care possible, the potential for growth was also identified.

Emotional Repercussions

Emotional responses identified in the narratives varied from sadness and regret to anxiety and frustration. Mental, physical and emotional exhaustion, which was linked to sadness and regret in the narratives, was mentioned five times and reported by four participants. Six of the 12 narratives identified feeling sad, and the root word “sad” appeared 10 times in the participants’ responses. The word frustration showed up four times, and anxiety also appeared four times. Finally, the word anger or angry was mentioned by eight participants and appeared fourteen times.

The emotional responses of sadness and regret often appeared together. For example, one participant shared, “When I reflect on that [the experience] I think about all of the things that I may or may not have over looked or things that got past me; how I could’ve advocated more, and it makes me sad” (P1). She went on to write, “these experiences are two-fold; while they allow me to learn and grow from them, I carry a heavy burden on being a piece of that person’s care that ultimately hurt or killed them” (P1).

Sadness and regret also appeared separately. P11 shared,

> The very first moment I was told I had to take care of him I literally started crying. I had already watched this man suffer so much when assisting with his care and then I would be the one responsible. The whole time period he was in the ICU was exhausting both mental and physically. Emotionally it was terrifying and really heartbreaking (P11).

After her experience in the operating room, where the doctor dropped an instrument and did not re-sterilize it, P6 wrote "I wanted to break down, but I held myself together" (P6). Another participant, who reflected upon the intubation of a patient who had previously stated they did not want extraordinary measures (such as intubation) performed on them wrote, "I felt like my heart was sinking," (P4). Regret was also present in this quote by another participant: "this situation will forever haunt me, I know I did all that I could have as a nurse and attempted to get help when needed, but the what ifs are the things that keep me up at night" (P10).

The root word *anger* was discussed by three participants while five participants shared the feeling of being angry.

P10 wrote,

> When I remember this situation, I still have a lot of anger and resentment. I feel sad for the family that I watched cry over their deceased loved one who was up until an hour ago, alert with eyes open (P10).

P11 wrote,

> I feel angry that people have to suffer like that. I feel angry that that woman was able to manipulate me and the other nurses that worked there and that we were forced to care for a man that I swear you could see it in his eyes was begging to die. I know that everything I did for him as a nurse was only meant to provide excellent care but that doesn't mean it didn't cause him pain (P11).

P8 shared, “Emotionally I was angry and sad. Angry at the medical and nursing staff for putting practice before patients and for being emotionally unattached to a human being…a tiny human being” (P8). P6 wrote, “I felt anger, conflict, shock, and powerlessness. I was angry that I was even in that room, well past the end of my shift […]” (P6).

Anxiety and frustration were other emotions that were linked in the narratives. P7 shared that the experience she discussed in her narrative “…caused me several days of anxiety and frustration. Just writing about it today gives me a feeling of despair over the current state of healthcare. The problem is too big to fix” (P7). P10 wrote,

> Usually I am a “leave work at work” kind of person. But there are times I have anxiety after getting off a shift about whether I’ve done something or not done something I should have when it’s come to patient care. People’s lives are not something I take lightly, and I struggle with the thought of possibly making a mistake. I love what I do, but the anxiety at times can be very overwhelming (P10).

Many participants expressed frustrations with how the healthcare system treats diseases. For example:

> I feel frustrated with the system. And think there has got to be a better way for treating these women antenatally or even before pregnancy. We do not have enough substances [sic] abuse or mental health beds to deal with issues that are leading people to drugs. I feel that we have a broken system that leads to broken people. I feel that newborns are now left more vulnerable in their living situations and more like to use drugs later in life just repeating they cycle (P2).

P8 also wrote about her frustrations with the healthcare system,

> My frustration comes back at the establishment. I start thinking of more and more events that are similar to this one. This event was not out of the ordinary for this establishment. I can recall several events where practice came before patient; unnecessary admits, unnecessary procedures, lack of communication, untrained staff, no current policies and procedures, lack of accountability, the list goes on and on (P8).

Another nurse wrote about her frustrations with systemic issues that lead to sub-optimal care,

> It frustrates me to think about these situations, honestly. It makes me feel as though we are placing more importance on getting people out the door than we are on making sure needs (ALL NEEDS) are met prior to discharge (P3).

The impact of anxiety and frustration was described as affecting professional relationships. P10 wrote how her experience with the emergency room doctor that was difficult to reach during a critical situation lead to resentment, "I resented this doctor and hated working with him every time after that" (P10). She continued to write,

> I feel like this situation has haunted me and given me a little bit of PTSD. How do I trust working with doctors who make these mistakes? How do we call these kinds of doctors out if the administration doesn't support our speaking out? (P10).

Physical Symptoms

Eight of the 12 participants shared the physical symptoms they experienced during their morally distressing event. Four of the eight discussed the symptoms of feeling physically exhausted or drained. Statements in this category included, "it was physically exhausting to care for this patient" (P5);"when this situation happened, I was drained, physically, emotionally and mentally" (P 10), and "the whole time period he [patient] was in the ICU was exhausting both mental and physically" (P11). While the physical feeling of exhaustion was most often

identified as a symptom of moral distress, other physical symptoms were identified as well. One participant shared, "I felt physically ill: diaphoretic, tachycardic, and restless. I had difficulty sleeping and was tying my stomach in figurative knots, ruminating on things I could not change" (P6). Another wrote, "Physically I felt sick to my stomach" (P8). A similar response was shared by P9, "Physically I felt nauseous and sick."

Career Implications

Inability to provide the best care possible. Inability to provide the best care was a source of moral distress that resulted from organizational issues and conflicts with the values of patients' families. One participant shared an experience involving a patient that stated they did not want to be intubated. The paperwork expressing these wishes could not be located, and when the patient became unresponsive and needed life support, they were intubated. The participant wrote, "I felt distressed to see a patient getting intubated although his/her family did not want intubation." (P4). She continued,

> It felt very conflicting to what I believe in which is to provide a quality of life rather than prolonging life. Clearly decisions were made to discontinue life on a piece of paper but simply because we could not find it, we failed to follow a patient or his/her family's wishes (P4).

Another participant (P 5) shared a time when she had taken care of a patient who was unable to verbally communicate. The patient, who had Do Not Resuscitate/ Do Not Intubate (DNR/DNI) order documented on her chart, was beginning to deteriorate. However, the family decided the patient should be intubated and revoked the DNR/DNI. The patient was intubated and placed on a ventilator, where she remained for weeks. The participant stated that eventually the family became less present at the bedside, however, they still demanded "everything be

done" and threatened to sue if it was not. The patient remained ventilated until she passed away. The participant described her experience as, "I felt 'bad' and guilty as though I was complacent [sic] in the mistreatment of this patient." (P5). She also wrote,

> I wished the patient could be provided comfort provisions instead of intubation/ventilation and BiPap. There was no reasoning with the family. It was physically exhausting to care for this patient. I dreaded work which was unusual at the time. I was relieved when I did not have this patient assigned to me (P5).

A third participant shared a different scenario where her values conflicted with her patient. She discussed feeling frustrated about discharging infants to homes where safety was a concern, but which were deemed safe by Child Protective Services (CPS).

> There have been multiple times that we [nurses] have simply shaken our heads wondering why the newborn is going home with the family at this time and hoping we do not read something tragic about them in the news. At discharge it does not always feel good and happy (P2).

This participant further explained why this scenario is distressing to her, "I want to support the family at the same time feeling frustrated with their choices" (P2).

Poor staffing was an organizational issue that was identified as impacting patient care, and which led to moral distress. As one participant said, "When the unit is busy, nurses are very pressured to discharge patients quickly in order to make room for more patients" (P3). She discussed the importance of thoroughly educating patients and their families, but felt she was not able to consistently provide quality patient education. She went on to reflect this practice is distressing because "I feel as though I'm failing my patients" (P3).

Burnout and the intent to leave. Symptoms of burnout were also present among the respondents, for example "this experience, alongside may [sic] others like it, has made me a little jaded as a person in general" (P7). One participant shared, "I almost became numb to situations because it happened more than I expected" (P4). P8 wrote, "I have put my heart and soul into this job…and I feel like a cold body to fill a position so the numbers look great" (P8). Participant P6 wrote, "nursing stress is unique, and the cumulative effect of morally distressing events has impacted my personal life" (P6).

Seven out of 12 participants explicitly stated intent to leave, ruminated on the thought of leaving, or recounted resignation from the unit on which the morally distressing experience occurred. P6 wrote, "It is deflating to think that I cannot beat the system, I cannot be everything to everyone all the time, and I cannot keep my patients [safe] from every possible harm." (P6). She went on to state, "I love trauma [nursing], but I cannot condone working at an institution where physicians are left largely unchecked and nurses leave in droves but are not replaced." (P6), and, "I considered leaving nursing altogether" (P6). That same consideration was made by another participant. She wrote, "It made me question whether or not I actually wanted to continue with nursing" (P9). One participant set a timeline for leaving, "I look forward to having a different job next year (contract end) and putting my family first again." (P8).

Some participants shared that they left their unit and even the facility. "It made me want to leave my job, which I did very shortly after that incident leave that hospital completely" (P7) Another participant wrote, "I choose not to be in an acute care setting anymore" (P4).

Growth. Strategies for navigating moral distress were shared by the participants and could be broken into three groups. They included: furthering education, becoming more careful and compassionate, and becoming a stronger communicator/ advocate. Two participants shared they

were furthering their education with hopes of initiating change within the healthcare system. Three participants noted their experience caused them to be more thoughtful, compassionate, and careful in the care they provided. The remaining six participants all identified this experience lead to them becoming a stronger advocate, for both the patient and them-selves. The ability to speak up and question things or ask for help and/or support were all strategies identified by the final six participants. Out of the 12 participants, the word grow or develop was written by five participants. Three specifically detailed their growth as a result of experiencing distress. P12 wrote about what she learned after her morally distressing experience,

> It reminds me to remain professional in my role, even if I have strong beliefs or feelings. It has also taught me to be more aware of policies and what to do in certain situations as this. It taught me that I as a nurse can advocate not only for my patients, but in the way I provide care to them (P12).

P2 wrote her frustrations from moral distress lead to her decision to continue her education,

> I think this is part of the reason I decided to follow through and get my master's degree in nursing, so I could have a bigger impact looking a bigger picture and try to help up stream (P2).

Six of the participants shared their growth would be through stronger communication and advocacy. P10 wrote,

> I have also learned from this situation which has been the only comfort. I make every effort to advocate for my patients, but I am also learning to advocate for myself as a nurse. It's okay to disagree with the doctor and I should speak up even though it may go nowhere (P10).

Another wrote,

> I am better at standing up for my patient/self in general […] I am more apt to talk to the charge nurse/manager/house supervisor when I feel there is a need to discuss a morally distressing or inappropriate behavior (P5).

Advocating for other nurses was also identified as a growth area:

> I will lift up my fledgling nurses to raise their voices even when it seems that no one hears them, because in time, with enough education and experience, we will be the people who make the rules, hire the staff, and hold one another accountable (P6).

Finally, P1 shared,

> As time goes on, the hurt goes from sharp to dull and we can reflect and grow from these instances. Next time I will be a bigger and better person, but sadly it is at the expense of all of those experiences that came before me to change me into this person. It has made me a more careful nurse and a more thoughtful person (P1).

Discussion

This study contributes to our knowledge of moral distress by providing an analysis of the experience as described by the nurses themselves. While other studies have examined the outcomes of moral distress on patient care and turnover of nurses (Choe et al., 2015), this study examined the effects of moral distress on patient care through the perspective of the nurse. This focus gave voice to the experiences of nurses. Furthermore, by allowing nurses to share their experiences through personal narratives, the researcher was able to uncover the complexities of moral distress. Based on the theory of Oppressed Group Behavior, thematic analyses of the narratives revealed that *not being heard* and *silencing of self*, had a key role in events that were

described as morally distressing. Whether through self-silencing or being dismissed, the feelings of not being heard were present in all the narratives.

When attempts to communicate are silenced or dismissed, detrimental effects on the nurse may occur. Morally distressing situations have been identified as having an inverse relationship with collaboration (Papathanassoglou et al., 2012; (Karanikola, Albarran, Drigo, Giannakopoulou, Kalafati, Mpouzika, Papathanassoglou, 2014)). When collaboration is poor, the nurse may not feel she is advocating for her patient. As a result, the nurse may begin to shut down and lose confidence in her abilities, which leads to self-silencing. When nurses lose confidence in their practice, the potential for growth may become stifled (Fricker, 2013). The inability to effectively communicate feelings may also be linked to marginalization (Fricker, 2013). Marginalization may occur due to the following reasons: (a) The individual is unable to put into words a way to express their negative experiences, or, as overwhelmingly evident in this study, (b) the individual may be able to express their feelings, but due to their position in the system, an individual may be discredited, dismissed, and not heard (Fricker, 2013).

Nurses' knowledge has traditionally been discounted due to their role and positionality in the medical hierarchy (Reed & Rishel, 2015). While nurses are frequently faced with many ethical dilemmas, Reed and Rishel (2015) highlighted the ethical dilemma of knowing. This dilemma occurs when the nurse has a medical knowledge base and holistic understanding of the patient but is not consulted while decisions are being made by the physician. The dilemma of knowing was observed throughout the narratives collected and may be a major component to feeling silenced.

In the study reported here, when a participant expressed moral distress resulting from poor nurse-physician collaboration, they indicated the feelings of resentment continued. This is

an example of moral residue which can lead to a crescendo effect (Epstein & Hamric, 2009). When moral residue occurs, the morally distressing event may end, but the remaining emotions and feelings continue (Epstein & Hamric, 2009). Returning to a pre-moral distress baseline is difficult and subsequent experiences increase the nurse's distress. All participants in this study identified the lingering impact moral distress had on their current personal and professional lives. While the initial experience was short in duration, this study confirmed the significance and lasting impact those experiences have on the individual female nurse. Because of the lasting impact of these experiences, some of the participants said they ultimately left the unit where the distressing event occurred.

Other studies have found a strong correlation between moral distress, and job burnout (Hamaideh, 2014). Burnout, defined as "a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding" (Schaufeli & Greenglass, 2001, p. 501), can result in depression, feelings of frustration and anger, feeling emotionally drained, and reduced job satisfaction (Espeland, 2006; Ajoudani, Baghaei, & Lotfi, 2018). While participants in the study reported here did not use the word burnout, they shared emotional and physical reactions consistent with burnout. These reactions included feelings of frustration, anger, and feeling emotionally drained.

Moral distress (Hamaideh, 2014), and burnout have both been identified as major risk factors for leaving a job **(**Ajoudani et al., 2018). In the study reported here, all the participants were currently practicing nurses. This subgroup of participants may represent the nurses that have learned to adapt and persevere through moral distress. However, since some participants spoke of wanting to leave their job, or that they had plans to leave in the near future, economic necessity rather than resilience may be keeping them in their current position. Future studies

should examine differences in resiliency between nurses who experience moral distress and remain in their positions, and those who experience moral distress and leave.

Unlike previous studies, the findings of this study indicate there is potential for growth following a morally distressing experience. Growth was found among those participants that left, or discussed leaving, the unit where the experience occurred. For those that stayed on the unit, growth became stifled. Although stifled, participants identified their experience served as motivation to move forward in their education.

While leaving the unit where the morally distressing incident happened was beneficial for the nurses in this study, this change was not in and of itself indicative of growth. Growth happened when participants found their voice after experiencing a distressing event and were able to assume advocacy for themselves and others.

Limitations and Suggestions for Future Research

As with any qualitative study, this study has limited generalizability. The sample size was small and limited geographically. More participants expressed interest in the study than completed it, and one suggestion for future studies of a similar nature is that the consent form and instructions should be sent together so participants can email them back at the same time. This strategy might have resulted in a higher participation rate. Another limitation was that the sample of the participants only included nurses that were still actively working as nurses, and this sample may be more resilient than nurses who leave due to moral distress. Future qualitative research on moral distress should study nurses who have left nursing. Narratives from nurses that have left nursing may provide further insight into the personal and professional toll of experiencing moral distress.

Another limitation of the study was that the responses were only recorded from the female perspective. While that was the aim of the study, a comparative study only involving male nurses may help identify similarities or differences that may be gender specific. While both men and women experience moral distress, their experiences may be different. Further exploration into gender issues may also help identify gaps between those that stay in nursing and those that leave.

Finally, because the principle researcher knew 10 of the 12 participants professionally, this may have affected the depth of the narratives. It is possible participants felt more comfortable sharing their feelings. It is also possible they may have withheld some experiences for fear of being judged. Lingo and terminology may have also been used by the participants that was understood by the data collector but may have been interpreted by another data collector differently. While the researcher made a conscious effort to set aside her biases and prior understandings of the topic, the limitations were still present.

Implications for Practice

The study reported here added to the body of knowledge on the subject of moral distress by including nurses from specialties, like medical-surgical nursing and labor and delivery, which, to the knowledge of the author, have previously not been studied in the context of moral distress. While the scenarios were different in the diverse settings participants worked in themes were identified that were universal to all the participants. This suggests that nurses in many different settings have the potential to experience moral distress, and that the outcomes will be similar. This finding suggests that interventions for moral distress should be considered in any setting.

This study also identified the potential to learn and grow from morally distressing experiences. This means that interventions should not just be focused on preventing morally distressing events but should also be focused on mitigating the response to these events. Interventions need to be aware of and honor the individual's experience. This can be done through the following two strategies. The first strategy should consider providing a safe environment for the nurse to share their experience. Since self-silencing and not being heard is a major part of experiences of moral distress, continued silence after the experience is harmful. Open dialogue can foster awareness of the severity of moral distress and can provide a venue for nurses' voices to be heard.

The second strategy, assertiveness building, and advocacy support should not just be taught, but should be part of the culture on the unit and in the hospital. Assertiveness training should take into consideration the history of the social construction of women compounded by the historical medical hierarchy system. Interventions should understand the embedded practice of self-silencing and should identify strategies to overcome self-silencing practices and raising awareness that self-silencing may be occurring.

Conclusion

With increasing professional demands, personal demands, and improving medical technology, experiences that are potentially morally distressing will continue to occur. The aim of this study was to shed light on and raise awareness to the unique experiences of the female nurse. The impact of self-silencing and the practice of being dismissed should be further explored to truly identify stronger and more effective interventions.

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Appendix A

The Moral Distress Scale-Revised (MDS-R)

Nurse Questionnaire (ADULT)

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

	Frequency					Level of Disturbance				
	Never Very frequently					None Great extent				
	0	1	2	3	4	0	1	2	3	4
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.										
2. Witness healthcare providers giving "false hope" to a patient or family.										
3. Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.										
4. Initiate extensive life-saving actions when I think they only prolong death.										
5. Follow the family's request not to discuss death with a dying patient who asks about dying.										
6. Carry out the physician's orders for what I consider to be unnecessary tests and treatments.										
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										

8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										
9. Assist a physician who, in my opinion, is providing incompetent care.										
10. Be required to care for patients I don't feel qualified to care for.										
11. Witness medical students perform painful procedures on patients solely to increase their skill.										

	Frequency					Level of Disturbance				
	Never Very frequently					None Great extent				
	0	1	2	3	4	0	1	2	3	4
12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
16. Follow the family's wishes for the patient's care when I do not agree with them but do so because of fears of a lawsuit.										
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										

18. Witness diminished patient care quality due to poor team communication.										
19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
20. Watch patient care suffer because of a lack of provider continuity.										
21. Work with levels of nurse or other care provider staffing that I consider unsafe.										
If there are other situations in which you have felt moral distress, please write them and score them here:										

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

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

Yes, I considered quitting but did not leave _____

Yes, I left a position _____

Are you considering leaving your position now? Yes No

Appendix B

Recruitment Letter

I am currently working on my capstone project for the EdD program at the University of Washington, Tacoma. I will be examining the lived experience of moral distress among currently practicing Registered Nurses working in an acute care facility. Moral Distress occurs when a morally compromising situation occurs, and while one knows the right thing to do, institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984). The American Nurses' Association (ANA) later went on to state that moral distress threatens the core values and moral integrity of the nurse (ANA, 2015, p. 44). The purpose of the study is to identify nurses that may have experienced a morally distressing experience in practice and give them the opportunity to share their lived experience and share the impact of their experience. Responses will remain anonymous. Volunteers interested in this study will be provided prompts including situations in practice that have been proven to lead to moral distress. If you choose to volunteer, and are selected to participate, you will write your experience and answer the prompts to the questions. If you are interested in participating please respond to this message, email me at zach83@uw.edu, or call me at 360-981-6780.

Thank you for your consideration,

Allison Wareham

Appendix C

Word Cloud