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Canadian Forces Military Nursing Officers And Moral Distress:

A Grounded Theory Approach

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Faculty of Graduate and Postdoctoral Studies
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the Degree of Masters of Science in Nursing

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Legend

CF – Canadian Forces

CF nurse – Canadian Forces' Nursing Officer

CoC – Chain-of-Command

CO – Commanding Officer

DART – Disaster Assistance Response Team

GT – Grounded Theory

ICU – Intensive Care Unit

MT – Medical Technician

MAC – Moral Action Choice

NATO – North Atlantic Treaty Organization

NNPL – National Nursing Practice Leader

Org - Organization

SPL – Senior Practice Leader

UN – United Nations

US – United States

Abstract

Background: Deployed military nurses frequently experience moral dilemmas in their delivery of care, putting them at risk to suffer moral distress.

Purpose: The purpose of this study was to understand the experience of deployed Canadian Forces nurses and moral distress.

Methods: A grounded theory approach provided the framework for the study's design and data analysis. Semi-structured interviews were conducted with ten nurses previously deployed on combat or humanitarian missions.

Findings: A new Moral Distress Model was developed reflecting four contributing factors to the development of moral distress: patient care delivery, chain-of-command, lack of moral preparation and training, and lack of professionalism. The central category – “unique environment” – suggests that moral distress is a two-part process: moral deliberation, and moral impact, influenced by the unique environment.

Conclusion: Moral distress was a prominent phenomenon affecting deployed CF nurses. Pre-deployment training and on-going educational and supportive strategies are suggested to mitigate the significant impact of moral distress.

Keywords: ethics, morals, nurses, military nurses, military personnel, decision making

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Chapter 1 – Introduction

Background

Nurses attempt to develop a relationship with their patients in order to gain a comprehensive understanding of the meanings patients attach to their illness. This intimate relationship helps guide the nurse towards appropriate interventions or courses of action with the patient's best interests and recovery in mind (Meleis, 2005; Wilkinson, 1987/88). Yet, nurses frequently face moral dilemmas in the delivery of nursing care, and the interventions they implement can be described as moral action. Moral action is the course of action a nurse attempts to implement to address a moral dilemma, and is based on the best interests of the patient but is also influenced by the nurse's personal moral framework (Gutierrez, 2005). However, factors such as staff shortages, changing technologies, organizational power structures, governing body regulations, cost control, culture, and individual loyalties may challenge and conflict with a nurse's personal moral framework, values, and beliefs towards ending the moral dilemma. Consequently, the influence of these factors and the nurse – patient relationship places the nurse at a high risk to suffer moral distress when the moral action is not put into action (Elpern, 2005; Gutierrez, 2005; Meltzer & Huckabay, 2004; Sundin-Huard & Fahy, 1999; Wilkinson).

Moral distress “occurs when a *decision has been made* regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action” (Canadian Nurses Association(CNA), 2003, p. 3). Moral distress has been linked to burnout, decreased quality of care, staff shortages such as sick time and turnover, and leaving the discipline altogether (Erlen, 2001; Meltzer & Huckabay, 2004; Sundin-Huard & Fahy, 1999; Wilkinson), in addition to a number of emotional, physical, social, and professional effects (See Appendix A). Notably, some of these effects include nurses being the sickest workers in Canada (CNA, 2003) and moral distress

affecting a large number (1 in 3) of nurses with 50% of nurses acting against their conscience (American Association of Critical Care Nurses (AACN), 2006a). The widespread impact of this “nearly universal phenomenon” (Hamric, 2000, p. 199), which the American Association of Critical Care Nurses (AACN) states is creating “a serious problem in nursing” (2006a, ¶1), suggests that moral distress needs to be recognized within all organizations that employ nurses, including military organizations, to “address and mitigate [its] harmful effects” (AACN, 2006a, ¶6).

The Military Context

Approximately 240 nurses, including generalists and specialists (e.g., critical care, operating room nurses), are enrolled in the military full-time as Regular Forces personnel. However, as approximately half of these nurses may not be available for deployment due to circumstances such as educational activities, illness or pregnancy, many of the remaining nurses may be involved in repeated deployments during their careers in the military. Canadian Forces’ Nursing Officers (CF nurses) work within two different environments during the span of their career: in-garrison and deployed. A CF nurse who is in-garrison typically works in Canada where the work environment tends to mirror that which is found in a civilian facility, such as the operating room, intensive care, emergency, medicine and surgery with similar tasks, responsibilities, and composition of the health care team. In addition, the social environment and the availability of social activities and support structures are usually the same as those seen with or available to their civilian counterparts.

The deployed CF nurse is a nurse who has been “deployed, or temporarily posted” overseas either on a combat mission such as the Gulf War, Bosnia, and Afghanistan or on a humanitarian aid mission with the Disaster Assistance Response Team (DART). However, the deployed environment involves aspects of nursing not characteristically seen within the in-garrison or civilian facility

environment. These aspects routinely involve dangerous work and living environment(s), difficult terrain, atypical patient conditions and injuries, differing cultures and languages, limited and finite resources, and the use of weapons and mandates directing to whom and how much care a given patient will receive (Fry, Harvey, Hurley, & Foley, 2002). As a result, the recognition of the phenomenon of moral distress within the deployed environment is especially relevant for the military organization to ensure optimal readiness and job effectiveness of their deployed nurses as health care providers, soldiers, and as individuals (Fry et al, 2002).

Statement of the Problem

In contrast to the current literature regarding moral distress and civilian nurses (McCarthy & Dedy, 2008), little is known concerning the effects of moral distress on the deployed military nurse serving on a humanitarian or combat mission, highlighting a lack of knowledge of moral distress and this nursing population. For example, do deployed military nurses experience moral distress similarly to what is presented in current research on civilian nurses? Is their experience of the moral distress the same? What effects do the environment and the number of deployments have on this nurse population

A recent database search conducted by the researcher in MEDLINE, CINAHL, EMBASE, Scirus, Cochrane Reviews, and PsychINFO revealed only one study by Fry et al (2002) on the topic of moral distress and its influence on military nurses, in this instance in the United States. To date, there are no published studies on CF nurses and their experience of moral distress. To address this knowledge gap, research is necessary to explore the process by which the CF nurse experiences moral distress, and the implications of moral distress for nurses and patient care.

Purpose and Objectives of the Study

The purpose of this study is to explore moral distress in deployed CF nurses. The objectives of the study are a) to describe the process(es) (i.e., the feelings, symptoms, sources, experiences, interactions, and strategies) and meaning(s) of moral distress in CF nurses who have been deployed overseas and b) to develop a theory and moral distress model to address the current gap in knowledge.

A number of recommendations currently exist in civilian nursing literature outlining management strategies to support nurses experiencing moral distress (AACN, 2006b; Corely, Minick, Elswick, & Jacobs, 2005; Harris, 2000; van Soeren & Miles, 2003) and instruments/tools that can be used to measure moral distress, such as Corely, Elswick, Gorman, & Clor (2001) Moral Distress Measurement Scale. However, the implementation of management strategies in the military context, that are based on the assessment of civilian nurse populations could lead to unsuccessful outcomes, since the process by which CF nurses experience moral distress is unknown.

This study is an essential step in addressing the lack of knowledge concerning moral distress within this population to reveal the process by which CF nurses experience moral distress. The lack of knowledge within civilian literature concerning moral distress at the individual, managerial, and organizational levels and the call for action to mitigate the impact of moral distress on the nursing discipline (AACN, 2006a), suggests that results of this study may be used by the CF Health Services Branch to enhance their knowledge and understanding of the impact of this phenomenon on the CF nurses. The results may also suggest the need for specific assessment tools, management strategies and organizational changes to optimize operational readiness of all deployable CF nurses at the organizational, base, unit, and section levels.

Chapter 2 – Literature Review

This chapter will present a review of the current literature on existing models of moral distress and the decision making process involved in the development of moral distress. Aspects specific to the military context will also be reviewed.

Search Strategy

A computerized database search was conducted in MEDLINE, CINAHL, EMBASE, Scirus, Cochrane Reviews, and PsychINFO using a keywords search and Boolean operators (See Appendix B). Additional search strategies included seeking library and collegial assistance, electronic searches of Canadian professional nursing associations' websites, and exploring the reference lists of relevant articles found in the search strategies. From these searches, articles were chosen based on their relevance to the topic being studied and separated into two groups: Moral Distress Studies and Moral Distress Discussion Papers. For the first group, each study was analyzed and organized by study, type or title, participants, purpose, time, measures, results, and comments. For the latter group, each discussion paper was analyzed by author, type of article (i.e., discussion, position statement, management strategy), and contribution to the understanding of the phenomenon.

Using similar key words, a literature search was also conducted on moral distress and non-nursing health care disciplines. The search revealed a few studies conducted with physicians and end-of-life care that only referred indirectly to morally distressing issues surrounding patient care (Oberle & Hughes, 2001; Simmonds, 1997).

Definition and Differentiation

Moral distress “occurs when a *decision has been made* regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action” (Canadian Nurses Association, 2003, p. 3). The resulting dissonance, understood as moral distress, produces a “psychological disequilibrium and negative feeling state” (Wilkinson, 1987/88, p. 16) resulting in such emotive responses such as frustration, anger, and anxiety (AACN, 2006b; Corley, Minick, Elswick, & Jacobs, 2005; Jameton, 1993). Research conducted with civilian nurse populations has also linked moral distress to burnout, decreased quality of nursing care, leaving the discipline altogether, and staff shortages caused by, sick time and turnover (Erlen, 2001; Meltzer & Huckabay, 2004; Sundin-Huard & Fahy, 1999; Wilkinson, 1987/88).

Moral distress is different from moral uncertainty and moral dilemma based on whether the nurse has made a decision to act or not (See Figure 1). If no decision has been made, the nurse will experience moral uncertainty or moral dilemma based on whether the moral options are known or not. However, if the nurse has made a decision but is blocked from executing it or is stopped during its implementation, the nurse will experience moral distress (Jameton, 1984).

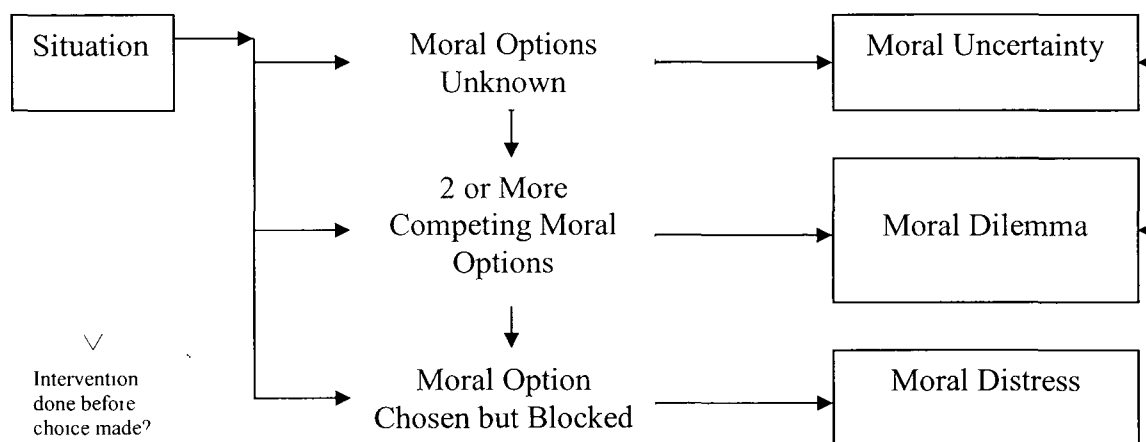


Figure 1. Difference between moral uncertainty, moral dilemma, and moral distress as illustrated in a proposed process towards a moral option decision.

Note. Figure adapted from Hamric (2000); Jameton (1984); van Soeren & Miles (2003).

The Decision Process

Gutierrez (2005, p 233) refers to the act of making a moral decision as a “moral action” Inherent in the definition of moral action is the understanding that ‘moral action’ includes decisions of action *and* inaction (Wilkinson, 1987/88) Jameton (1993) suggests that a nurse employs a three-step decision process when faced with a moral situation (1) based on values of right or wrong, the nurse evaluates the known moral options, (2) then decides what should be done, and (3) chooses whether to put that decision into action or not However, a moral decision is rarely straightforward, and as Jameton (1993) describes, a moral decision can often be “unpredictable, [with] marginally useful outcome[s]” (p 544) and requires a nurse to take risks, take on more work, and obtain collegial support while dealing with the interpersonal conflict the decision created (Jameton, 1993) Research has shown that when a ‘moral action’ choice is made and is blocked, a nurse will experience moral distress in two consecutive forms (See Figure 2) – initial and reactive distress (Jameton, 1993) – whereby

“Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values [and] reactive distress is the distress that people feel when they do not act upon their initial distress ” (Jameton, 1993, p 544)

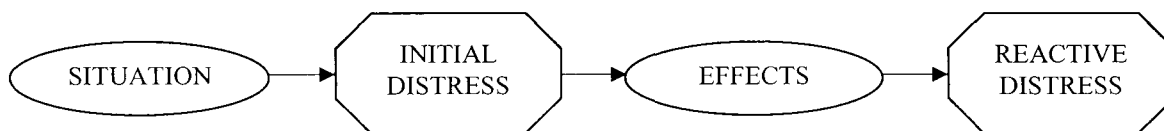


Figure 2 Two consecutive forms of moral distress

Note Figure from “Development of a model of moral distress in military nursing,” by S T Fry, R M Harvey, A C Hurley, and B J Foley, 2002, *Nursing Ethics*, 9(4), p 375 Copyright 2002 by Hodder Arnold Reprinted with permission from author

Influences on the Decision Process

Moral distress is an individualized, complex, multifaceted process influenced by past experiences, contextual factors, and self-imposed questions such as: What is possible for me to do? Will changes be possible? Is this worth trying or is it futile? Have my experiences been positive or negative? What personal risks are involved? (e.g., falling out of favour with team/colleagues, career implications) (Jameton, 1993). As a result, the same moral situation may cause high levels of moral distress for one nurse but will not necessarily cause the same high level of moral distress in another nurse (Wilkinson, 1987/88). Current research on moral distress has shown that the situation, its effects on nurses' wholeness and quality of care, their moral sensitivity, and sense of responsibility to the patient are key determinants in the level of moral distress the individual nurse experiences (AACN, 2006a; Gutierrez, 2005; Hamric, 2000; Jameton, 1993; Wilkinson, 1987/88).

An individual's past experiences influence the process of deciding what moral action will be chosen (CNA, 2003). These experiences are recalled and re-examined whenever similar situations and/or stakeholders are involved (Nathaniel, 2006). They shape future perceptions of one's self, others, available resources, and the chances of having a positive outcome when the nurse must make another moral action decision (Wilkinson, 1987/88). In the case of moral distress, it is proposed that past experiences tend to be more damaging to the decision process, as they have previously elicited "psychological disequilibrium and a negative feeling state" (Wilkinson, 1987/88, p. 16) within the nurse and as a result, predispose him/her to another negative outcome. This understanding implies that the outcomes of moral distress tend to go far beyond the situation itself and can have a long-term, cumulative effect on the individual, defined by Webster & Baylis (2000) as "moral residue". The detrimental, cumulative effects of moral residue have been linked to increased inaction, often in the face of a desire to act. As a result, the agent blocking this desire to act becomes the nurse himself or herself,

resulting in a higher feeling of responsibility and the accumulation of more destructive levels of moral distress (CNA, 2003; Webster & Baylis, 2000).

The influence of contextual factors are most often seen in situations where nurses deal with the following situations: prolonging life and suffering, treatments with little perceived benefit, inaccurate or partial information given to the patient and family, staff shortages, increasing technology demands, and inadequate resources and can be divided into internal and external factors. Internal factors include errors in judgment, lack of awareness, self-doubt, low personal resolve, inadequate nursing skills, fear, powerlessness, socialization, futility of past actions, and personal values incongruent with the hospital and/or physician. External factors consist of poor administrative or managerial support, lack of time, organizational policies, power imbalances, legalities, and threats to personal security (AACN, 2006b; CNA, 2003; Corley, 1995; Corley, Elswick, Norman, & Clor, 2001; Corley, Minick, Elswick, & Jacobs, 2005; Elpern, 2005; Erlen, 2001; Gutierrez, 2005; Hamric, 2000; Sundin-Huard & Fahy, 1999; Wilkinson, 1987/88). Ultimately, the impact of all of these influences on the moral decision process is multifaceted and cumulative in its effects and has been shown to negatively affect the nurse. Many have been reported to: (a) “lose their capacity for caring, avoid patient contact, and fail to give good physical care; (b) experience physical and psychological problems, and; (c) physically withdraw from the bedside” (AACN, 2006a, ¶3).

Moral Distress and the Military Nurse

There is little research that deals specifically with moral distress as experienced within the military nurse population. As a result, research has not clearly shown whether civilian findings are applicable to the military context, particularly among deployed nurses. For example, the military culture of following orders (Fry et al., 2002) or the underlying intolerance and disdain for emotional distress (the

individual is viewed as being weak) (Marin, 2002; St. John's Ambulance, 1996) are not captured within current civilian research. Moreover, the effects of deployment on the military nurse and healthcare delivery are unknown. For example, shifts in personal and organizational bioethical principles may result from the realities of a combat or humanitarian deployment, where:

“A patient's rights to life and self-determination contract; human dignity strains under the barrage of military necessity; and the interests of the state and political community may outweigh considerations of patients' welfare” (Gross, 2004, p. 22).

To address this lack of knowledge, research is required that considers the unique working environment of deployed nurses (See Table 1) and the resultant effects on the nurses' process of reaching a moral action decision. It can be hypothesized that the impact of moral distress on military nurses will be related to the unique factors they face while deployed (e.g., operational and clinical readiness, weapons use, how resources impact triage, and medical rules of engagement). For example, American military nurses in Iraq are currently facing a number of problems concerning the question of to whom they are ultimately responsible for their nursing care delivered in a war zone (Agar-Neuman & Blakeney, 2005; Fisher, 2005; Mason, 2004). The key problem lies in their military mandate that allegedly determines whom they can or cannot treat; a position, which conflicts with the regulations outlined by the nurses' respective regulatory bodies in the United States (Agar-Neuman & Blakeney, 2005; Fisher, 2005; Mason, 2004). Hence, difficult questions arise that contribute to the development of moral distress: *Whom must the nurse obey? To whom are they responsible? With whom do their loyalties lie? What are the repercussions and risks if they obey one but not the other? What choices have other nurses made? Will the nurse be alone or supported in his or her choice?*

Table 1

Military Deployment Conditions Affecting Nursing Care

Condition	Description
Unique Setting	<ul style="list-style-type: none"> • Difficult environmental conditions (weather, temperature) • Difficult terrain • Insect, reptile and rodent infestations • Smells, sounds, and tactile sensations often negative • Unfamiliar colleagues and leadership • Living arrangements
Dangerous Environment	<ul style="list-style-type: none"> • Threats of violence • Chemical and biological warfare • Exposure to missile attack, small arms fire, mines • High noise and heat • Wearing of protective clothing (e.g., helmet, gas mask)
Atypical Patient Conditions	<ul style="list-style-type: none"> • Battle casualties and multiple deaths • Trauma victims and mutilated patients • Endemic diseases • Exposure to infectious diseases • Post-traumatic Stress (Battlefield Stress)
Military Triage	<ul style="list-style-type: none"> • Guided by scarce resources and facility capabilities – not everyone can be saved • Goal of getting soldier back to service
Suggested Additions to Fry et al (2002)	
Cultures	<ul style="list-style-type: none"> • Civilian cultures knowledge of and potential conflict with western health care delivery • Military culture – following orders, being a strong soldier • Nursing culture – potential shifts in application of bioethics
Resources and Resupply	<ul style="list-style-type: none"> • Limited resources • Stock levels based on mandate, statistics, operational tempo • Resupply can be slow and may not meet demand
Time Lines	<ul style="list-style-type: none"> • Specific patient holding time lines (e.g., 48 hours in ICU before discharge, transfer, or repatriation)
Weapon Use	<ul style="list-style-type: none"> • Geneva Convention and Rules of Engagement • Use of weapon to protect themselves and patient
Deployment Readiness	<ul style="list-style-type: none"> • Clinical and operational nursing competency • Soldier and survival skills • Personal/physical/psychosocial factors • Leadership/Administrative • Group integration and identification
Mandate vs Regulatory Body	<ul style="list-style-type: none"> • In Iraq conflict exists between operational orders and civilian regulatory bodies with nurses caught in the middle (Agar-Neuman & Blakeney, 2005, Fisher, 2005, Mason, 2004)

Note Table adapted from Fry et al, 2002, Gross, 2004, Remeck, 2001

Deployed military nurses are expected to practice in a unique high paced environment requiring expert levels of competency even though they may have limited deployment experience and/or preparation, in addition to being separated from their traditional support systems (Fry et al., 2002). This unique environment and change of support systems suggests that higher levels of moral residue (Webster & Baylis, 2000) will exist related to the hypothesized increase in the intensity and frequency of moral distress situations.

Stress, Distress, and Moral Distress

An appreciation of how stress influences the development of distress is necessary for an understanding of the process of moral distress. Stress and distress are terms that are often used synonymously. Both elicit physical, psychological, social, and professional effects within the individual experiencing the situation (AACN, 2006a; CNA, 2003; Corley, 1995; Corley, Minick, Elswick, & Jacobs, 2005; Elpern, 2005; Gutierrez, 2005; Harris, 2001; International Council of Nurses, 2005; Parikh, Taukari, & Bhattacharya, 2004; Robbins, 2005). However, where stress can be either positive or negative; distress is frequently considered to be negative (McCarthy & Deady, 2008).

The aspect of distress being negative suggests an ongoing and long-term effect. The moral situation evoking the feelings of distress tends to be vividly remembered and continues to evoke lingering emotions such as guilt, sadness, anger, and self-blame, even years later (Nathaniel, 2006). In addition, the negative outcomes of moral distress will be cumulative and increase the individual nurse's moral sensitivity to future situations (Webster & Baylis, 2000; Wilkinson, 1987/88). Collectively, the outcomes of moral distress predispose the nurse to experiencing higher levels of distress (Boss, 1988; Lavee, McCubbin, & Patterson, 1985; Lazarus, 1999), which may lead to emotional exhaustion (Meltzer & Huckabay, 2004).

Earlier models of stress, which studied the process by which an individual responds to a stressor (Boss, 1988; Folkman, 1997; Lavee et al, 1985), illustrate the link between the effect of past experiences and unresolved dilemmas on the person's deliberation process and future decisions. Hill's 1958 ABC-X Model of Stress (Boss, 1988) and Lavee et al's (1985) expansion of Hill's model reveal how the effect of unresolved stress and/or poor adaptation places the individual at a higher risk of reaching a crisis state, at which point the individual's ability to function and cope is beyond their capabilities. The model of stress developed by Folkman (1997) also suggests that outcomes in dealing with stress will affect one's appraisal of the situation as either benign or a challenge, and the ability of the individual to cope with another future stressor will be influenced by past experiences and unresolved stressors. What is important to note in these models is how the effects of unresolved stress accumulate and affect one's ability to cope with the demands of the stressor(s) being faced.

For example, in her Moral Distress Model, Wilkinson (1987/88) suggests that a nurse will stay or leave the nursing discipline as a result of his or her decision-making process, the outcomes, and effects of the decision made. This model acknowledges how the negative experiences harm a nurse's wholeness, however, the cumulative effect of this harm on the nurse's future decisions is not as clear as the "loop back" effects of cumulative stress illustrated in the previously mentioned stress models. These stress models demonstrate that negative outcomes and/or unresolved stressors place the individual closer to a crisis state (See Figure 3). In addition, the effects or existence of chronic reactive distress is not clearly captured in Jameton's (1993) definition of reactive distress. Consequently, further research is necessary to develop a comprehensive moral distress model that illustrates the loopback effect caused by moral distress and its cumulative effects on future dilemmas and the decisions made, as seen in stress models. The usefulness of such a model would be timely for all military organizations, many of whom

have recently seen a significant increase in their operational tempo, operational danger levels, battle injuries (both civilian and military), and a decrease in the length of time between deployments.

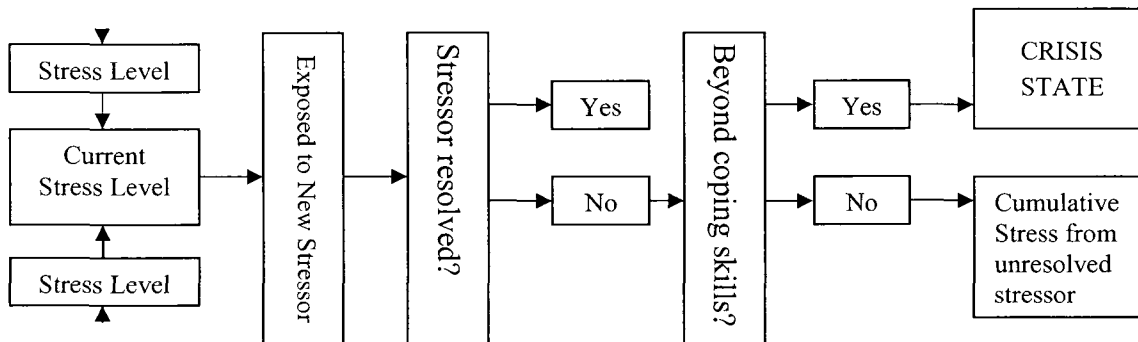


Figure 3: Loop back effects of cumulative stress leading to a crisis state.

Note Figure adapted from Boss, 1988, Lavee, McCubbin, & Patterson, 1985; Lazarus, 1999

Summary

Moral distress is a frequent occurrence within the nursing discipline (AACN, 2006a). The relationship of moral distress to burnout, turnover rates, nurses leaving the discipline, decreased quality of care, and increased sick time are relatively well researched, yet few nurses recognize the term moral distress and its causes (Hamric, 2000; Wilkinson, 1987/88). Organizations may also not recognize moral distress as being a priority issue for their nursing staff, if they are not aware of the impact of moral distress or its existence. As a result, the development and implementation of evidence-based interventions to address moral distress within the organization/facility may be hampered when determining the allocation of resources and funding to address staffing problems (AACN, 2006a).

While civilian recognition of moral distress is growing (McCarthy & Deady, 2008) and intervention strategies for the civilian population exist (AACN, 2006b; Corley et al, 2005; Erlen, 2001), an understanding of the concept of moral distress and its impact on CF nurses is necessary to address the knowledge gap that currently exists between the effects of moral distress on deployed nurses and the

impact of these effects for the individual nurse, the military organization, and society. It is suggested that studies of this nurse population are fundamental to enhancing individual and organizational recognition of the impact of moral distress, for developing and implementing management strategies, and supporting the use of resources to address moral distress issues that affect CF nurses.

Chapter 3 – Methods

This chapter will outline the study's design, data collection process, and data analysis. Also presented is a discussion of grounded theory methodology and the process followed by the researcher to ensure methodological rigor.

Study Design

Current literature has illustrated the widespread impact of moral distress within a number of civilian nursing populations. However, little is known about the effects and impact of moral distress on the deployed military nurse serving on a humanitarian or combat mission. To address this gap in knowledge, a qualitative grounded theory approach was employed to capture the “dynamic, holistic, and individual aspects of human experience...within the context of those who are experiencing them” (Polit & Beck, 2004, p. 16). Grounded theory (GT) allows for a flexible and evolving approach using concurrent data collection and analysis to illuminate and develop theory on the phenomenon of interest (Polit & Beck, 2004).

The use of a GT approach for examining moral distress and CF nurses is particularly useful based on its symbolic interactionist view of human behaviour and GT's systematic approach to exploring and generating a theory about the phenomenon (Chenitz & Swanson, 1986). Symbolic interactionism focuses on explaining the nature of ‘meaning’ and how it is developed where “human beings go through a continual process of adaptation in the constantly changing social world” (Jeon, 2004). Symbolic interactionism also creates a social product based on three principles: (a) the meaning people have for a given thing will determine how they act towards them; (b) meaning is derived from social interaction, and; (c) how a person deals with situations will modify and influence these meanings (Blumer, 1969).

These principles emphasize the individuality of human behaviour and serves as the basis for GT to translate this social product from “private experience to common language and processes” (Crooks, 2001, p.16). In effect, GT modifies the intrapersonal interaction seen in symbolic interactionism to a conceptual or theoretical view of the phenomenon, its processes (Crooks, 2001), and relationships (Chenitz & Swanson, 1986; Strauss & Corbin, 1998). As previous studies conducted with the civilian population have described moral distress as an individualized process (Wilkinson, 1987/88), GT’s symbolic interactionism provides a theoretical framework that reflects the context of the environment that influenced the experiences of the CF nurses in this study, and the meanings they ascribed to their experiences .

Sample

With qualitative inquiry, a sample is not selected based on certain population variables but rather the initial sample is purposefully based on where the phenomenon is found to exist (Chenitz & Swanson, 1986). As data is collected and analyzed, GT utilizes theoretical sampling after the initial sample to assure representativeness of the sample through continual testing of new data against previously developed codes, categories and theories (Chenitz & Swanson; Holloway & Wheeler, 2002; Strauss & Corbin, 1998). In other words, the sampling is not planned (Holloway & Wheeler, 2002) but rather “the logic of sampling and the site for data collection are guided by analysis” (Chenitz & Swanson, 1986, p. 9). Overall, the use of coding, memos and diagrams, and the theoretical sampling process serve to gain the richest data and develop a central category for the phenomenon under study (Chenitz & Swanson, 1986). The GT qualitative approach addresses this study’s objectives by revealing the process through which deployed CF nurses experience moral distress.

In this study, purposive sampling was employed to enrol participants who could provide information concerning their experiences with moral distress. Purposive sampling consists of potential candidates being selected or sought out for a study based on a characteristic they possess or belong to (Polit & Beck, 2004). In this case, the sample was purposive in that the participants had to be CF nurses who had been, but were currently not on a deployment. Participants were sought from both small and large military bases to determine if accessibility to the base's support infrastructure had any influence on the participants' experiences. In addition, sampling included potential participants of all ranks, gender, and age groups to gain an adequate representation of the population being studied. The sampling method continued to seek out those participants who would provide rich data and based on emerging themes from constant comparative analysis. The only change in data collection method occurred with the inclusion of telephone interviews to expand the number of potential participants for enrolment due to timelines imposed by the CF that allowed access to enrol and interview CF personnel.

Eligibility Criteria

Participants who had never been deployed and CF nurses currently deployed were not approached for recruitment. Inclusion criteria required each participant to be a registered nurse currently serving in the Regular or Reserve Force of the Canadian Forces who had completed a minimum of one overseas combat or humanitarian mission. Combat missions included those with the United Nations (UN) or North Atlantic Treaty Organization (NATO), which typically lasted for 6 months. Although humanitarian activities do take place during a combat mission, the main objective is one of combat – including peacekeeping – rather than humanitarian. Humanitarian missions consisted of those missions with the Disaster Assistance Response Team (DART), and typically lasted for 40 days. DART missions were included because it was believed it would present a number of challenges to CF nurses not typically

seen in UN or NATO tours such as development of non-governmental agency relationships for ongoing health care after the CF departs, and disaster related issues (e.g. poor resupply, limited resources, lack of available water, and poor infrastructure). Additional inclusion criteria were that participants had to be fluent in spoken English, as the investigator does not speak French. This helped to ensure accurate data collection, while minimizing potential errors caused from a possible misinterpretation.

Demographic variables such as age, gender, and marital status were not considered as inclusion or exclusion criteria. It was expected the data gained from this study would illuminate how these variables could potentially influence the participant's experience(s) of moral distress. Another variable not used for exclusion criteria was the amount of time that had elapsed since the participant's last tour. The reason for this was twofold: 1) it was believed that setting a timeline could significantly limit the number of potential participants for enrolment, and 2) within current literature on stress, there are conflicting points-of-view concerning time and its effect on the intensity with which individuals may still feel the stress elicited and how clearly they recall the event as being either relevant (Cohen, Kamarack & Mermelstein, 1983) or irrelevant (Lazarus, 1999).

Process of Recruitment and Enrolment

Approval to conduct the study was received from the University of Ottawa and the Canadian Forces' Research Ethics Boards. Recruitment consisted of two phases: 1) regional participants for face-to-face interviews, and 2) national participants for phone interviews. For the former, each Commanding Officer (CO) was emailed an introductory letter outlining the study (See Appendix C). Attached to this email were the following electronic documents: an advertisement poster – to be placed in a high traffic area – (See Appendix D and E), an introductory email for the potential participant (See Appendix F), an information letter (See Appendix G and H), and a consent form (See Appendix I and J). These

documents were sent to potential participants via a third party representative authorized by the CO, who also served as the investigator's point-of-contact. Interested individuals then contacted the investigator and any questions or concerns were answered and arrangements were made to set up the interview if they still wished to enrol.

Potential national participants were included in the recruitment phase upon approval of data collection method changes by the Research Ethics Boards. The steps employed for recruitment of this sample were the same as those used for regional participants. However, electronic documents were sent to the Canadian Forces National Nursing Practice Leader (NNPL). Upon approval by the CF Surgeon General, the NNPL disseminated the information to all the Senior Practice Leaders responsible for all CF nurses across Canada. The NNPL also served as the point-of-contact and third party representative for potential national participants.

The Interview Process

Individual interviews were conducted with ten CF nurses (see Appendix K). Before commencing the study, a pilot interview was conducted, with a health care provider with deployment experience, to assess the original interview structure and questions. After reviewing the interview transcript with the thesis supervisor, amendments were made to the interview format. This was done to improve flow, minimise repetitiveness, encourage open and participant directed discussion, to improve question clarity and gain rich data concerning the phenomenon. Moreover, the resulting amendments to the format established a flexible structure to guide the investigator, in addition to providing flexibility for the investigator to introduce new questions. This ensured that rich data was attained for each interview. Once the formal interviews commenced, responses to the interview questions, both verbal and non-

verbal, were analyzed utilizing grounded theory and constant comparison throughout this process until data saturation was achieved.

The Consent Process

Participants read and signed consent forms before beginning the interviews and indicated whether they consented to be contacted at a later date for participation in the validation phase. Participants were also informed that the investigator would be taking hand written notes during the interview. For the regional participants, participants reviewed and signed their consent forms in front of the researcher prior to commencing the interview. Participants retained a copy of the consent form for their records. The national participants hand-signed or electronically signed a consent form that was sent to them in the introductory email. They then scanned the signed consent form and returned it by email to the investigator. Prior to beginning the telephone interviews, the participants confirmed that they had signed an electronic form and this confirmation was recorded on tape. In addition, two Official Consent Forms were sent via Priority Mail for their signatures, once this confirmation was complete. One copy was returned to the investigator and the other copy was kept by the participants for their own records.

To address the possible concerns of the participants regarding their confidentiality within the military organization, they were reassured that their stories and comments would remain confidential through the use of participant coding and the removal of the operation's title, location, and rotational number in the transcripts, data, and thesis.

The Interview

Data collection was accomplished by means of an audio-recorded semi-structured interview, in which participants were asked questions about their experiences with morally challenging situations

while on deployment (See Appendix K). A semi-structured interview consists of a predetermined set of questions, which the investigator may use in conducting the interview as a way to gain data about the phenomenon (Polit & Beck, 2004). The questions serve as a guide or template and may be amended, removed, or added to depending on the participant's response to illuminate their experiences by probing key points or data from the interview (Chenitz & Swanson, 1986; Fain, 2004; Polit & Beck, 2004). In addition to the interview, the investigator used hand-written notes to further illuminate data by noting key words, gestures, tones, and silence (Strauss & Corbin, 1990).

To protect the anonymity of the participants, the interviews were conducted after work hours at a non-military facility of the participant's choosing. All interviews were recorded on a digital recorder and the investigator transcribed the interview into a Microsoft Word document within 24 hours. The short time span between conducting the interview and the subsequent transcription allowed the investigator to remember key verbal and/or non-verbal cues. To ensure accuracy, each recording was replayed and compared with the completed transcript.

Before beginning the interview, demographic questions were asked to provide information to assist in identifying trends and to help establish rapport and set the participant at ease (Dawn Adams, personal communication, April 7, 2006). The following demographic information was obtained from each participant: gender, age, marital status, number of children, years in nursing, years nursing in the military, time span between nursing licensure and first deployment, number of deployments, deployment auspice (e.g., UN, NATO), job title, type of work and living structure (e.g., canvas, building), and danger level of mission. After acquiring demographic data, the participants were then asked questions about their experiences with moral distress. Upon completion, each interview was assigned an individual number to protect the participant's anonymity and confidentiality. Numbers were assigned in the order by which the interviews occurred.

Within each transcribed interview, any aspects that could identify the participant were removed and annotated in bold (e.g. country's name, person's name, roto number (number given to each mission rotation starting with 0), operation name, job position). The average interview length of the ten interviews conducted was 45 minutes and ranged from 29 to 72 minutes.

Data Analysis

To achieve a theoretical view of a phenomenon, GT employs constant comparison throughout its approach. Constant comparison requires that all incoming data is first analyzed and then these findings are compared to previous data for similarities and differences until data saturation has been reached (Strauss & Corbin, 1998). Data saturation is accomplished through a systematic process of coding procedures, memo writing, diagram development, theory testing, and testing in subsequent interviews and data collection (See Figure 4 and Appendix L).

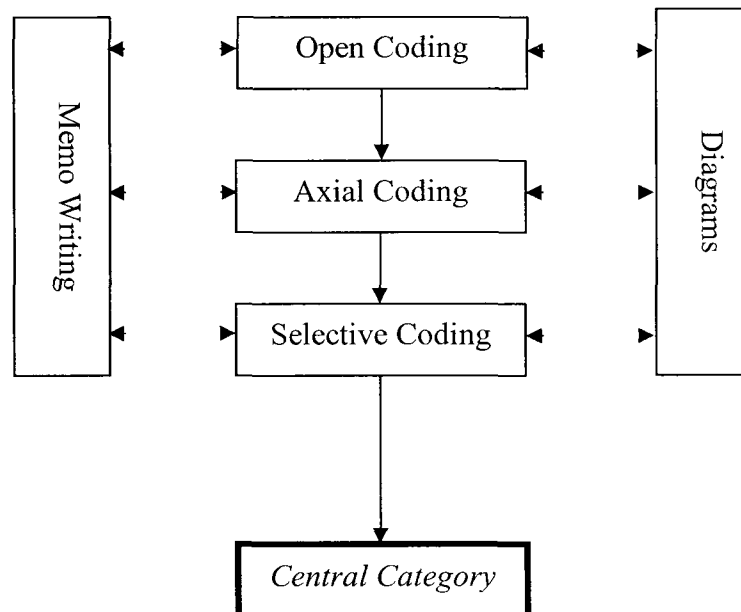


Figure 4. Systematic process of coding and influence of memo writing and diagrams towards the designation of a central category

Note. Figure adapted from Chenitz & Swanson (1986); Holloway & Wheeler (2002); Strauss & Corbin (1998).

In keeping with the process of GT (Strauss & Corbin, 1990), data analysis began with a line-by-line analysis of each interview. Beginning with the first interview, key passages in the interview holding specific meaning and impact to the individual and/or illuminating the processes and factors by which they experienced moral distress were underlined. Each underlined passage was subsequently assigned an open code, which the investigator created to fully capture the essence of each passage. During the analysis, any questions, points-of-interest, ideas, or passages requiring more input, investigation, or description than what the assigned open code captured were written on the side and annotated as a memo. Throughout the coding process, additional notes were made to outline passages that could serve as code exemplars. Small diagrams were also employed to tie in the investigator's thoughts, ideas, and outline trends to help augment the data analysis so that the investigator would be able to gain a clearer understanding of the process involved in the participants' experience of moral distress.

Upon completion of the line-by-line analysis (Strauss & Corbin, 1990), the transcribed interview was imported to the QSR International qualitative data analysis program NVivo 7 (NVivo, 2006), where the underlined passages were highlighted and assigned their respective codes termed "open nodes". Additional points of interest requiring minimal explanation were highlighted as annotations. However, key points of interest, points requiring an in-depth explanation, and/or trends to watch or questions to answer were "memo linked" to the respective interview file they came from. All open nodes, annotations, and memos were created, found, and entered by the investigator. At no time was NVivo 7 used to determine any code, link data/trends, or any other type of analysis other than to centralize and document data.

All subsequent interviews included the same process. No changes to the interview or analysis processes was required to attain rich data. Upon completion of the analysis phase, each interview was then compared with all of the other interviews preceding it to note similarities and/or new avenues of

analysis. This was accomplished by comparing the open codes from the previous interviews listed in NVivo 7. Any new open codes were then numbered at the top of the interview transcript as a means to track for data saturation.

Upon completion of Interview #9, no new open codes were discovered. One additional interview was conducted to determine whether other open codes still existed within the population. Analysis of Interview #10 revealed no new open codes or findings and when compared to all other interviews. At this point, it was determined by the researcher and the thesis committee that data saturation had been obtained. Subsequently, a coding summary of all the interviews was completed utilizing NVivo 7. This summary outlined every open code and listed each quoted passage supporting open codes and their sources. This summary also served to complete the constant comparison of the interviews by ensuring that the newer open codes found in later interviews were or were not contained within the earlier interviews. From this summary, each open code was reviewed for its content to determine the axial codes by means of the paradigm model approach (Strauss & Corbin, 1990). Strauss & Corbin's (1990) paradigm model approach was employed for determining axial codes. This paradigm consists of causal conditions, phenomena, context, intervening conditions, and action/interaction strategies, which seek to find new connections after open coding has been completed (Strauss & Corbin, 1990). The paradigm model approach outlines a linear-like process of analysis where the data reveals: what causal conditions → the phenomenon → what properties and dimensions of the phenomenon (e.g., intensity, duration) create conditions → strategies considered and implemented to mitigate the phenomenon → but may be influenced positively or negatively by intervening conditions such as: space, gender, time, knowledge, and culture (Chenitz & Swanson, 1986; Fain, 2004; Strauss & Corbin, 1990).

In determining the central category – the central code to which all other codes are connected – (Strauss & Corbin, 1990), the investigator posed a number of questions (See coding notes in Appendix

M) to create a story line or a conceptual narrative of the phenomenon and its central category (Strauss & Corbin, 1990). The answers to these questions were developed by a review of the open coding summary and axial coding, diagrams, and memos, which helped to provide an overall sense of the data, illuminate the process and contribute to the building of a model of moral distress (See Table 2). Furthermore, the creation of this story line and continual constant comparison assisted in determining that data saturation was attained at Interview #10. Data saturation occurs when no new codes emerge and when a central category can be related/connected to all other codes (Chenitz & Swanson, 1986).

Table 2

Example of Coding Process

Quote	Open Code	Axial Code (Paradigm Process)	Central Code
“This kid had no family. So he has no one to reposition him...he came back to us”	Capabilities of Civilian facilities	Patient Care Delivery	Unique Environment
“You have one still alive but you can’t save them but you have four you can...you have to leave that one. You can’t save them.”	Ability to Save		
“We do have a document but it is used only at people’s convenience...it’s just a guideline”	Regulation Convenience	Chain-of-Command	
“...people that have no connection, they were reprimanded but if you’re well connected, then they kind of let [it] go”	Regulation Claiming vs Application		

Methods to Ensure Rigor

In their criteria for judging the quality of research using this method, Strauss & Corbin (2008), noted that it “is better to let the research findings speak for themselves” (p. 305) as the quality will be judged by others. However, Strauss & Corbin (2008) outlined a number of general criteria to evaluate the quality of qualitative research, which are illustrated in Table 3 and defined in the following section.

Table 3

Strauss & Corbin’s (2008) Criteria to Evaluate Qualitative Research

Criterion	Definition
Fit	Findings are said to “fit” when the findings ring true to the researcher and the participants for whom the research was intended. Can participants feel that all findings relate to them even when all aspects may not apply to them?
Applicability	This pertains to the <i>usefulness</i> of the findings and whether they offer new insights, which can lead to change and add to knowledge.
Concepts	To ensure a common understanding of the findings, the development of concepts is necessary and the findings having substance to open discussion and for the reader to be able to follow the study.
Context	Without the researcher providing the appropriate context, the reader will not get a full understanding behind the concepts and the accompanying story, which will render the findings incomplete.
Logic	Logic refers to the flow of the ideas and that the findings make sense.
Depth	In addition to concepts, the use of descriptive details adds to the richness and variation of the findings.
Variation	Have variations been built into the findings to capture those that may reveal differences with some properties or aspects of the study? This is the basis of symbolic interactionism, which GT is built upon.
Sensitivity	Was the researcher sensitive to the participants and data? Did the researcher take into consideration the participant during data collection and were the questions driven by the data or by preconceived ideas?
Creativity	Are the findings presented with creativity and originality or do they just put old ideas into a new way?
Evidence of Memos	For the findings to be accurate, the researcher must have used memos to capture ideas, questions, and insight throughout the process and did not rely solely on recall.

Fit

Throughout the data collection the investigator, based on personal experience working in similar military deployment contexts, was able to relate to many of the participants' stories and the emotions they expressed. The study's findings were also reviewed by the thesis committee and a Mental Health Nurse to determine if the findings fit the population under study. The thesis committee provided ongoing feedback to ensure proper application of GT throughout the study. The Mental Health Nurse provided feedback as a subject matter expert based on professional experiences in working with this population. The findings were also reviewed by three randomly selected consenting participants, who were given the opportunity to review all of the study's findings and the conceptual model to see if these findings accurately reflected their experiences.

Applicability

While the findings of this study provided support to current literature, this study did provide a new view of this phenomenon and its potential impact to the individual, team, chain-of-command, and organization through its development of a two-step process of moral distress consisting of moral deliberation and moral impact. This two-step process expands the current definition, which is primarily based on a blocked action, to include the deliberation process an individual will go through when faced with a moral dilemma.

Concepts

The investigator employed Strauss & Corbin's (1990) method where the concepts of the findings revealed themselves through interpreting each line to define and create an open code, application of axial coding/paradigm model approach, and selective coding in determining the central code of the "Unique Environment". This central code led to the concepts of moral deliberation and moral impact as being inclusive under the phenomenon of moral distress.

Context

The investigator provided a synopsis of current literature to give the reader an understanding of moral distress and outline those aspects from the literature that applied to this study's population. The findings were also given context, using models, figures, tables, scenarios, and key quotations found from the stories of the participants.

Logic

To ensure that the findings followed a logical sequence and to minimize gaps, the investigator explained the findings by outlining the demographics of the sample, describing the four contributing factors to moral distress, within the unique environment, and how these factors and the central code led to the creation of a new model consisting of two steps. Detailed explanations were provided to support the process of analysis utilized in this study

Depth

Similar to fit, the researcher employed the use of multiple quotations throughout the findings to provide a common language of the population under study and provide a vivid picture of the moral distress these participants experienced.

Variation

The development of the moral impact phase of moral distress took into consideration differences in participants' experiences, particularly in the areas of situational resolution and self-reflection, while recognizing those aspects of individuality that will affect the intensity and degree of the moral distress experienced.

Sensitivity

Due to the sensitive nature of this study, prior to beginning the interview each participant was provided with the contact information of a designated person, who could provide them with professional

support if required. While the investigator employed a semi-structured interview, which remained consistent throughout the study, these questions served as a guide only and additional probing questions were asked to gain further insight or to seek out data for questions revealed in the investigator's memos. All attempts to remain true to the data were employed, including ongoing thesis committee reviews, memos, and diagrams.

Creativity

The investigator attempted to provide a creative approach to the phenomenon of moral distress through the proposal of new ideas in the two-step process of moral distress and by incorporating the feedback loop and crisis states found in stress models/studies into the process of moral distress.

Memos

The researcher utilized NVivo7 and developed a number of assumptions and memos to guide further interviews. However, NVivo7 was not used to develop codes, trends, or concepts. In addition, hand-written notes, memos, diagrams, development of a storyline (see Appendix M), and the paradigm model approach were employed, particularly in the development of the model.

While other methods to ensure rigor exist, these ten general criteria for qualitative research evaluation (Strauss & Corbin, 2008) were applied to this study, as they provide a clear and concise format to ensure rigor in the study's findings of this population.

Protection of Human Rights

Research can create a number of ethical issues that may cause significant harm to participants and therefore, must be considered (Polit & Beck, 2004). To plan this study, consideration was given to the bioethical principles of beneficence/non-maleficence, respect for human dignity, justice, informed consent and vulnerable subjects.

Participants in this study were Regular Force (full-time/career) members of the Canadian Forces. Therefore, ethical approval was attained from the Canadian Forces Ethical Review Board and the University of Ottawa Ethical Review Board to conduct this study. Once approval was granted from both bodies, administrative authorization to approach prospective participants came from the National Nursing Practice Leader and from each participant's Commanding Officer.

The primary investigator is also a CF nurse with a more senior rank than most of the potential candidates for this study. Consequently, a third-party representative for each unit was utilized to display recruitment posters and distribute information letters via email to ensure that the participants did not feel coerced into participating because they were subordinate to the investigator's rank. Therefore, initial contact with the investigator only occurred when the participants contacted the investigator to express interest to enrol in the study.

Prior to enrolling in the study, potential participants were made aware of the purpose and goals of the study, why it was important, who would be collecting and accessing the data, the possible risks, and that appropriate support (e.g., mental health nurse, clergy, social worker, and/or physician) had been arranged for the participants to access if they felt that participating in the interview created significant emotional distress for them. In addition, all participants were informed that participation in the study was voluntary and that they could choose to leave the study or refuse to answer any questions or have themselves quoted if the study was published. Most importantly, because participants could choose not to participate, answer certain questions, or be quoted, it was assured there would be no repercussions to their careers. If they chose to participate in the study, a copy of the informed consent containing the investigator and supervisor's contact information was given to them.

All of the participants' data was identified by a designated number throughout the study to ensure that their confidentiality was protected and that no identifying information would be revealed in any of

in the interview transcripts or future publications (e.g., demographic information, what unit the participant belonged to, or quotations used in publication). Data was kept in a locked cabinet in the investigator's home for the study's duration and upon completion of the study; all documentation will be kept by the Canadian Forces as PROTECTED documents with access only granted by the Canadian Forces under the Access to Information Act. However, the study remains the property of the University of Ottawa, which approved retention of the data by the Canadian Forces.

Summary

The use of GT as a relevant study method approach is two-fold. Firstly, GT is based on symbolic interactionism, which focuses on explaining the nature of 'meaning' and how it is developed (Jeon, 2004). When considering that literature, in which study participants were nurses employed in a civilian setting, has described moral distress as an individualized process (Wilkinson, 1987/88), GT's symbolic interactionism roots provide a clearer picture based on its three principles: (a) the meaning people have for a given thing will determine how they act towards them, (b) meaning is derived from social interaction, and, (c) how a person deals with situations will modify and influence these meanings (Blumer, 1969).

Secondly, based on its employment of constant comparison of all collected data towards the development of a theory and central category (Chenitz & Swanson, 1986), GT provided the investigator with the flexibility to seek out participants who could describe a wide range of personal and professional experiences that involved moral distress. Therefore, GT's individualized symbolic interaction, in addition to its flexible approach and constant data comparison, was seen as the method to best achieve the study's purpose. The purpose of this study was to explore the phenomenon of moral distress in deployed Canadian Forces Nursing Officers, to describe the process(es) and meaning(s) of moral distress

in deployed CF nurses who have been deployed overseas, and ultimately to develop a new moral distress model to address the current gap in knowledge.

Chapter 4 – Findings

This chapter will outline the demographics of the population studied, and introduce a new Model of Moral Distress. The two-phased process of moral distress, its key factors, and the resulting impact on the Canadian Forces Nursing Officers (CF nurses) who experience moral distress are presented. General scenarios provide the contextual background to the presentation of the findings.

Demographics of the Participants

Ten CF nurses, nine females and one male, who met the inclusion criteria, participated in the study. All participating CF nurses currently served in the Regular Force and each had completed one deployment ($n = 7$) or more ($n = 3$). Most participants lived and worked in buildings ($n = 8$) versus under canvas structures such as modular tents while deployed. Over 50% of the ten nurses did so in highly dangerous environments. The participants' deployment(s) were as part of a Canadian Contingent for, the North Atlantic Treaty Organization ($n = 6$) the United Nations ($n = 2$), or on a Disaster Assistance Response Team mission ($n = 2$). Additional demographics are illustrated in Table 4.

Table 4

Demographics

Demographic	Range	Median
Age	26 – 53	34.5
Total Years Nursing	3 – 31	9
Total Years Military Nursing	3 – 28	6
Licensure to Deployment	1.5 – 23	3.75
Marital Status	Married ($n = 5$); Single ($n = 3$); Divorced ($n = 2$)	

A New Model of Moral Distress

A new Moral Distress Model (Figure 5) was developed based on the results of the grounded theory and paradigm model approach to data analysis (Strauss & Corbin, 1990). The Unique Environment is identified as the overriding theme in this model, as it provides a special context that influences all aspects involved in the development of moral distress in this nurse population.

From the CF nurses' stories, the data illustrated how the CF nurses experienced a significant amount of stress during their process of coming to a decision, which appeared to be as stressful as moral distress caused by the blocked action alone. As a result, the overall process of moral distress could not be solely linked to moral distress caused from blocked actions, but should be expanded to include the process of how CF nurses came to a decision. Figure 5 illustrates a two-phased Moral Distress Model consisting of Phase 1: Moral Deliberation (in blue), resulting in moral distress being experienced (in green) or not (in red), and Phase 2: Moral Impact (in burgundy). The two-phased model outlines the process involved in the development of moral distress as a result of the deliberation and moral impact processes, and includes the constant influence of the Unique Environment on all aspects of the moral deliberation and moral impact process.

Contributing Factors of Moral Distress: Common and Specific Factors.

The paradigm model approach to data analysis employed in this study (Chenitz & Swanson, 1986; Fain, 2004; Strauss & Corbin, 1990) revealed that within the unique environment, there are four major contributing factors involved in the development of the moral distress that are elements of the unique environment encountered in this nursing population. These four major contributing factors of moral distress were; Issues around Patient Care Delivery, Chain-of-Command, Lack of Moral Preparation and Training in Moral Dilemmas, and Lack of Professionalism. The data also revealed that the process by which CF nurses experienced moral distress consisted of two phases – moral

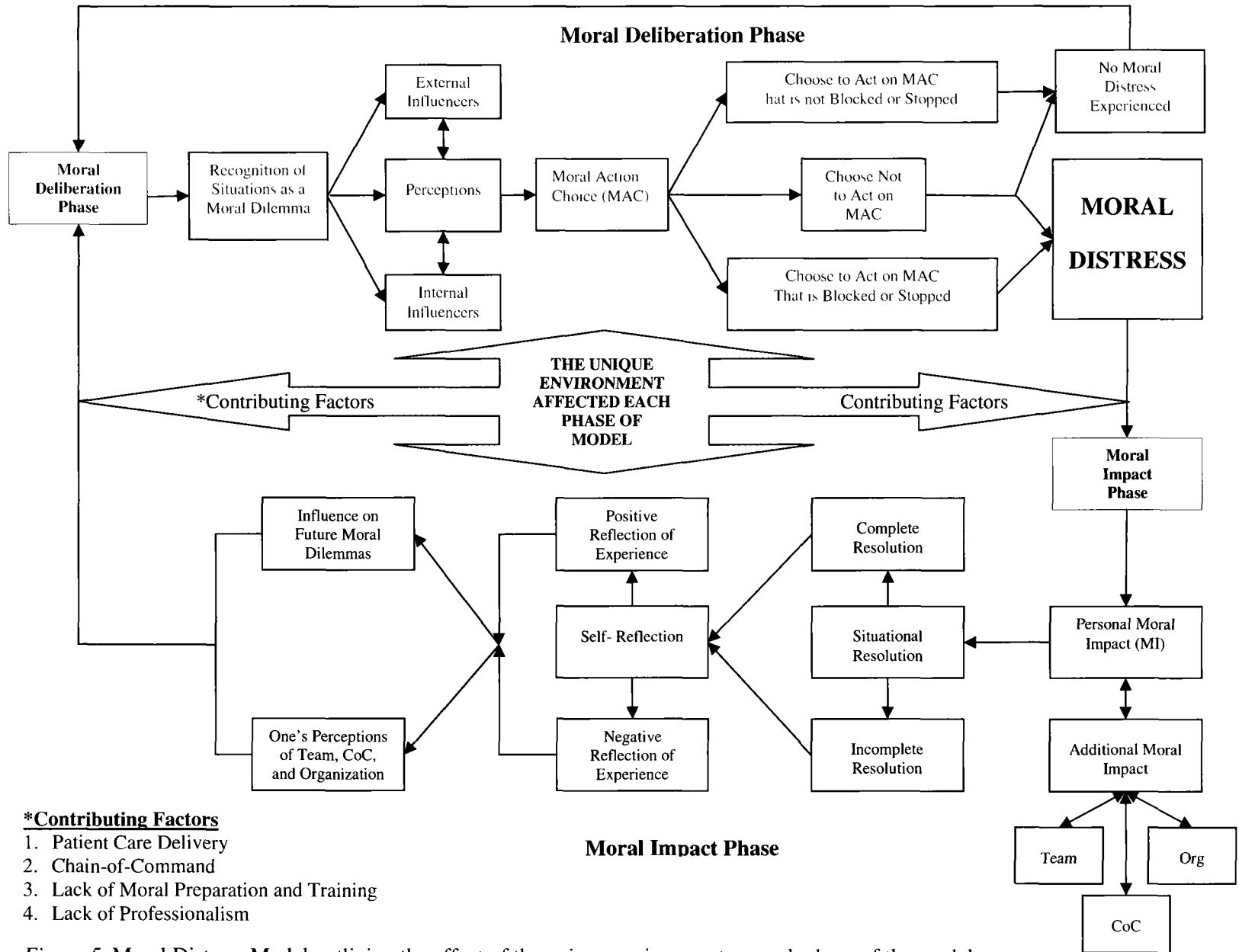


Figure 5. Moral Distress Model outlining the effect of the unique environment on each phase of the model.

deliberation and moral impact – and that each contributing factor was influenced by the central category of the Unique Environment, reflecting its significant effect on each phase of the process.

Each contributing factor included common and specific themes consisting of properties, strategies, and intervening conditions. For example, specific themes for Patient Care Delivery consisted of codes such as Type of Patient and Staffing/Resources, and included factors with codes such as Level of Responsibility, Acceptance of Moral Action Choice, and Nurse/Physician Dynamic/Power. Some codes were only attributable to a particular contributing factor. For example, the code “Type of Patient” was found to be a specific property to Patient Care Delivery, but was not attributable to the other contributing factors.

The following section presents each contributing factor in depth using scenarios and supporting quotations from the participants that reflect the findings. The scenarios are included to provide context to the presentation of the findings. To ensure anonymity, the CF nurses’ quotations are identified according to a system, based on participant number. Furthermore, the scenarios are not factual, but were created from the data analysis and *represented* the nurses’ stories. Due to the relatively small size of the nursing branch in CF Health Services, using real scenarios would not guarantee anonymity.

Contributing factor 1: Issues around patient care delivery

Patient care delivery refers to all aspects of health care delivery, and includes patient type and resources (e.g. human, supply, space, etc.). Issues around patient care delivery were the most common contributing factor of moral distress for the CF nurses. The type of patient and the resources available were two key driving factors as to whether the CF nurses experienced moral distress and the impact the situation had on the CF nurses when moral distress occurred. While the nurses’ stories often focused on

the type of patient, the availability of finite resources was a common underlying factor that had a significant effect on patient care delivery.

The following scenario describes a typical deployed setting and how the issue of finite resources and resupply to meet demand influenced how health care was delivered, the prioritization of care entitlement, and the length of time care could be provided within the facility.

Scenario 1: You are an ICU nurse working in a 3-bed ICU. One bed is occupied by a critically ill civilian who has required mechanical ventilation for the past three weeks and resources are strained. The tempo over the past week has been gruelling with long hours, and you just moved to new housing for the third time. You are exhausted. Two critical casualties, an enemy soldier and a 9-year-old civilian non-combatant, are on route and due to arrive in 15 minutes. Both are successfully resuscitated and are to be admitted to the ICU. This will fill all the beds in the ICU. As you prepare the patients for admission, you receive word that three more critical casualties are due to arrive in 20 minutes. All these casualties are Canadian soldiers who were allegedly critically injured by the enemy soldier you just treated in the trauma bay and whom you will be looking after in the ICU. When the casualties arrive you see that all the Canadian soldiers are from your base, and you are good friends with some of them.

Issues around patient care delivery: type of patient

Within the context of a deployment, the type of patient refers to whether the person being treated was a civilian or combatant. Civilian patients include local civilians from the country in which the mission takes place and civilians hired to work for the mission, which may include local civilians and those from supporting agencies (e.g., Non-Governmental Organizations). The term also includes combatants. Combatants are fighters or soldiers who can be either an enemy or allied force or group. These include defined militaries (CF, US, British Army, etc.), police organizations (e.g., Afghan National Police), combatant groups not readily defined as military force (e.g., Taliban) due to

funding/supply and often plain clothed (no defined uniform designating them as a military or combatant). The type of patient is not related to demographic characteristics such as age and gender, but is related to whether they are from the country the mission takes place in (host country) or if they are part of the force or humanitarian group that comes to the aid of the host country.

The type of the patient was an important factor in the moral dilemmas faced in the delivery of health care by the nurses. If injured Canadian or coalition soldiers presented themselves to the facility, the process employed by the health care team was simple: treat and return the soldiers to the frontlines or treat and send the soldiers home for more definitive care and/or rehabilitation. If the injured persons who presented to the facility were local civilians, the process was more complicated. While the quality of care delivered remained the same for all types of patients, aspects such as; medical rules of eligibility or entitlement to care, the use of finite resources, and the country's poor or non-existent health care infrastructure were factors that influenced the delivery of care to civilians. Many CF nurses felt that the delivery of patient care within the military facility to local civilians/combatants was often a futile and frustrating process. The nurses' opinions are reflected in the following quotes:

Well this is when we decide that we can't do any more for him. Give him pain medication and we sent him off to die. What did we do in that six weeks? Should we have continued on for six weeks? Or should we have realized at some point, even in the weaning process, that he's not going to have any backup, he has no support. We're not helping him. All we're doing is prolonging the suffering. If we had let him go in the beginning, he wouldn't have suffered for six weeks (Nurse 1).

It also was a little bit more frustrating for the nurses as well because when you're delivering care to an individual and giving your all...it's almost for naught because in three weeks time when we leave, this patient is going to die (Nurse 2).

The poor quality and availability of health care frequently seen in the deployments to these countries created a sense within the CF nurses of "When do we say no?" and "What good are we doing?" instead of "Who can we save?" when they were faced with the delivery of health care to patients who were either civilians or combatants.

Issues around patient care delivery: resources.

Resources also played a key role in the development of moral dilemmas surrounding patient care delivery. Resources refer to those aspects necessary for the ongoing operation and maintenance of the military health care facility to deliver health care. Resources can be classified into two types: external and internal. Examples of external resources are staffing, space, time, amount and type of supplies, resupply, how well the team works together, and whether the team supports each other in all aspects of the deployment (i.e., team cohesion). Internal resources include the individual nurse's personality traits (e.g. confidence, fortitude), experience, and energy level (e.g. fatigue).

The findings of this study revealed that the host country's patients, civilian and combatant, negatively impacted both external and internal resources, as the overriding purpose of the mission was to use the available resources to provide care to Canadian and/or UN/NATO coalition soldiers. Therefore, any additional strain on the amount of resources utilized in the care of civilian patients led to a sense of trepidation within the CF nurses. This unease was more apparent when key supplies (e.g. IV lines, medications, blood, bed space) were used on civilian and/or combatant patients whom the nursing staff

felt would most likely not survive once discharged, or were used during a lengthy and ultimately unsuccessful resuscitation. Moreover, the constant threat of mass casualties involving Canadian soldiers was always expected to occur and further increased the nurses' concerns, particularly surrounding bed availability and resources, especially when key supplies were already low and resupply was not readily available. In humanitarian missions, supplies remained an issue but more from a resupply aspect than from the threat of mass casualties involving Canadian soldiers. However, this possibility was always planned for, in case it occurred. The following quotes reflect CF nurses' perceptions of how the delivery of health care was influenced by lack of resources:

[We were] advocating for the withdrawal of care on a very regular basis... [as] we don't have tons of resources and they [the physicians] think they can save everybody and you can't (Nurse 1).

You know what your treatment options are but then you, but they're not Canadian and you only have so many units of blood...when do we say, No? (Nurse 4).

The CF nurses also struggled with a sense of competing loyalties in their delivery of care. As nurses, they delivered care in keeping with their professional associations' directives, but as soldiers, they also felt that it was their duty to protect the finite resources for Canadian or coalition soldiers regardless of the type of mission:

That makes a difference because that's your family...we treat them like our brothers (Nurse 1).

Talking to people who are overseas now is that we were maintaining our resources. You don't want to waste resources on [civilian] patients. God knows when we're going to get bombed. We may need them ourselves (Nurse 5).

The level of moral distress that occurred for CF nurses when caring for enemy combatants and its impact on them in the course of delivering patient care is illustrated in the following quotes:

This guy here, in this bed, had high explosives in his, in his head because he was trying to set them to blow up these guys. And all I wanted to do at that point was unplug the machine (Nurse 1).

The guy that actually shot them [a Canadian soldier] and you have to look after that one first, it, it isn't a pleasant thought (Nurse 3)

Because looking after [an enemy combatant] is not the same as looking after our own soldier...so it create dilemma, that's for sure (Nurse 4).

I am more shocked...by the resigned nature of the [enemy combatant] to just die...and keep his leg, when he had a family and everybody (Nurse 6).

It was perceived by both myself and the others...an inequality between an enemy force and a friendly force (Nurse 7).

Contributing Factor 2: Chain-of-Command.

During a mission, the chain-of-command (CoC) consists of three major levels: the immediate supervisor, the Commanding Officer (CO), and the Contingent/Mission Commander. While these individuals have a number of roles to fulfill during a deployment, three roles pivotal to mitigating moral distress that were within their areas of responsibility were revealed by the data: a) leading by example, b) being supportive, and c) ensuring the well-being of their subordinates.

The following scenario reflects a situation where the nurse perceived that the CoC failed to enforce regulations because of personal loyalties and/or connections, and consequently failed to fulfill their role as commanding officers:

Scenario 2: Last week Pte Bloggins (fictional name) was sentenced and sent home because he consumed alcohol beyond the allowed amount. Next month, despite numerous warnings from your supervisors about the regulations surrounding alcohol consumption, you notice a CF nurse consume more alcohol than the allotted amount for your tour. This CF nurse is your tour best friend and you believe others will consider you a snitch, so you choose not to report it. Later in the tour you notice the same CF nurse consume more than the allotted amount of alcohol. This time you choose to approach the CF nurse and tell him to stop this or you will report the situation if it happens again. The CF nurse becomes very angry and threatens to make your life a living hell with your colleagues and superiors regardless of whether you report the incident or not. This outburst compels you to report the CF nurse to your chain-of-command. The chain-of-command does not pass sentence on the CF nurse as it leads to repatriation, loss of his medal, and will negatively impact his career, despite the sentence being different than Pte Bloggins'.

Through the CF nurses' descriptions of their experiences, the CoC was revealed to be a contributing factor of moral distress if the senior command structure, particularly the CO, failed to fulfill any of the pivotal roles. These CF nurses explained how the CoC affected them:

That is very disappointing when for a group of people that have no connections, they were caught, they were reprimanded. But then if you're well connected they kind of let you go...that is a frustration (Nurse 4).

There's two parts that affect me the most, one was the failure in senior leadership to act on a charge that was recommended...and two, what that did to [those] who were brave enough to stand up for what is right...what is their belief now? (Nurse 6)

There's a certain level of complacency...people were so overwhelmed with life in general overseas, and you're only over there for six months...but it doesn't ever seem like we can get on top of things and make anything change (Nurse 5).

Do what you say you're going to do and, and that there's some continuity...there isn't a special set of rules for some people and a special set of rules for other people (Nurse 7).

The perceived inability of the CoC to support the CF nurses and listen to the issues at hand had a significant impact on how the nurses viewed their CoC and the organization as a whole. In the following quotes, nurses described the effect on them of this lack of support:

I felt that the chain-of-command wasn't entirely transparent in their dealings with [us]...I felt let down or marginalized by the chain-of-command (Nurse 7).

I lost faith in a system that I believe in to action something that was wrong (Nurse 6).

Not standing behind the regulations that you have to impart is a sign of weakness...you need to follow up and you need to stand behind people when rights have been affected... I guess my expectation is that nothing will happen, which is quite disappointing, which is certainly something that's very detrimental to our branch (Nurse 6).

Overall, the data revealed the significance of the moral impact on the CF nurses and subsequent development of moral distress that resulted from failure of the CoC to act equitably, in a timely fashion, and in a manner to maintain good order and discipline of all the subordinates that they are responsible for.

In difficult situations or experiences with the CoC (management) in the civilian sector, civilian nurses can go to their respective nursing association(s) directly for assistance. In the military sector, CF nurses, although they are still able to access their respective provincial regulatory associations, they are also officers and soldiers. As a result, the CF nurses are also bound to the CF Health Care facility, the Medical Rules of Eligibility (MROE), including other rules and regulations. These rules and regulations are controlled, implemented, and enforced by the CoC and not the nursing association.

The intensity of the moral impact was considerable for the CF nurses if they perceived that the failure of the CoC to act in accordance with CF or mission rules and regulations as expected. The intensity was more apparent if the CoC's failure to act was based on loyalty to professional colleagues

and rank, connections, and/or if the disciplinary action was only to occur back in Canada after the deployment.

Contributing Factor 3: Lack of Moral Preparation and Training in Moral Dilemmas.

The findings revealed that the CF nurses felt well prepared for their roles as soldiers and nurses, but were unprepared to deal with the moral dilemmas they faced, while deployed, such as disobeying an order and whether to report the infraction or not, social moral dilemmas (e.g., fraternization), and medical moral dilemmas. Prior to a deployment, all medical personnel undergo a comprehensive series of training sessions to prepare them for a mission. These training sessions include soldiering skills, clinical skills, team building, and development. Soldiering skills focus on mission specific training sessions designed to prepare personnel as soldiers and include topics ranging from re-qualifying on weapons, cultural lectures, and mission briefings. In preparation for deployment, all medical personnel worked in civilian clinical facilities (e.g., hospitals) to augment their current knowledge and skills and/or increase their exposure to infrequently seen injuries/diseases (e.g., burns, trauma, malaria). This phase also includes completing mandatory courses (e.g., Cardio-Pulmonary Resuscitation, Advanced Cardiac Life Support, and Trauma Nursing Care Course).

Collective training includes both clinical and soldiering (e.g., re-familiarization on weapons). Although this collective training encourages teamwork and camaraderie, and is the first opportunity for these individuals to develop and build their team, the training does not provide the team members with the opportunity to prepare for the moral dilemmas they may encounter during their deployment.

The CF nurses' perceived lack of moral preparation and training to deal with a moral dilemma is highlighted in the following scenario:

Scenario 3: You are deploying overseas for your first mission. After all the clinical and military training, you feel you are more than ready to take on anything that will come through the trauma doors. On your first shift, you are part of a trauma team providing emergent care to a 4 year old child who was indiscriminately shot by a member of the country's army. Regrettably, the child does not survive. Since the death, you frequently recall how beautiful the child was, the disgust and anger you felt, and what you would do to the person who shot the child. Unfortunately, in a terrible coincidence, on your next shift you are assigned to look after the soldier who shot the child. During the shift, the soldier requests something for severe pain but you struggle with the anger you still feel towards the act he committed and your duty to provide the appropriate level of care. As you walk out to get the analgesic, your anger wins out and you wait an hour before administering the medication, feeling fully justified in this delay. However, as you lie in your bed that night, you begin to struggle with your decision and realize that you were not really prepared to deal with this kind of situation. As a result, you find yourself questioning why you never received the necessary preparation before you deployed.

As their stories unfolded, the CF nurses initially described their experiences in terms of training as officers and as clinical nurses. However, they went on to describe situations that revealed how they felt unprepared for many of the moral dilemmas they encountered, and suggested that training in medical moral issues should have been an essential part of their pre-deployment training. The participants believed that if they had been given the opportunity and time by the military organization during their pre-deployment training to consider and discuss their reactions and feelings in these types of situations, they might have been better prepared with skills to mitigate or prevent much of the moral distress experienced during their deployment. The nurses also recognized that many previously deployed CF

nurses did not share their experiences or strategies with those going on a later deployment, which if they had, would have helped them to anticipate some of the challenging moral situations they eventually encountered. In the following quotes, the nurses share their thoughts surrounding their lack of preparation for these issues:

I didn't find that people were talking *nearly* enough of what to expect or what types of moral challenges to expect (Nurse 5).

We need to find better ways to morally and ethically prepare our nurses for what they're going to face on the planet (Nurse 8).

I never thought I would have to face that (Nurse 4).

We don't seem to share those things. We share clinically what we need, how we need to prepare so they can face those clinical situations and save lives, which is fantastic, but there are a lot of *really difficult* situations ethically that those nurses are facing and...I don't think that nursing school can provide you adequately with those tools to deal with those situations (Nurse 8).

I'm quite sure that the level of discussion of those kinds of things is pretty minimal because it focuses so much on clinical. So there has to be something we can do to have discussions, to even give nurses an idea of what they might face on the ethical side of things. So that at least in their minds, they have preparation of how they might deal with those situations (Nurse 2).

It [the training] didn't really prepare us to not do what we're used to doing...not being able to make them pain-free, to look after them, to cure them...there was none of that going on (Nurse 5).

Contributing Factor 4: Lack of Professionalism.

The final contributing factor of moral distress revealed by the data was the lack of professionalism between disciplines (e.g., medicine and nursing) and rank (e.g. officer versus non-officer and rank structure within each group). The CF nurses understood professionalism to connote mutual levels of recognition and respect, team dynamics and stakeholder equality, all of which should occur within the maintenance of rules and regulations and/or the delivery of health care. The following scenario depicts a situation between health care team members on a deployment that highlights a lack of professionalism between the nurse and physician:

Scenario 4: As you walk into Canada House, you overhear a senior ranked physician discussing with a Medical Technician (MT)(non-officer) that nurses are not required in the military and most of them (nurses) are a bunch of princesses and whiners. You approach the table and state that this discussion is inappropriate. The physician states that you are okay and not part of that group. Nevertheless, you stand firm on the point that this discussion is inappropriate and the conversation moves onto other topics. Later you think about the discussion between the physician and MT knowing that the physician as an officer should set the example for subordinates (MTs) to follow and emulate. You become concerned that the MTs will follow the physician's example, negatively affecting the team dynamics between CF nurses and MTs in areas such as respect and working relationships.

While lack of professionalism and respect and power imbalances between CF nurses and physicians may have occurred at other times in the CF nurses' careers, the data revealed that nurses' level of moral distress was compounded by feelings of marginalization, the absence of professional recognition, physicians' lack of respect for CF nurses' moral decisions and the impact of the contributing factors in the unique environment. Participants described the lack of professionalism towards the CF nurses in the following quotes:

What it's like to work in an environment where you're not respected as a professional? Like, not as a person, but as a profession...I've always found in the military, as a nurse, that I've had to prove myself first (Nurse 5).

The surgeon should have come out and explained to the staff why he did what he did and then stayed there and assumed responsibility for his actions when that patient woke up. Because it's not the nurses on the ward who decided to take his leg, but they're the ones left with the ramifications of that from the patient's perspective (Nurse 6).

There's not only the nurse-doctor dynamic, but there's the rank too, the rank dynamic (Nurse 4).

Each group of doctors that came in had their own predisposed ideas and depending on the group...were not willing to listen to people who have been there longer (Nurse 7).

You're over-ruled very easily...almost to the point where my opinion wasn't really counted (Nurse 3).

[The physicians were] unwilling to discuss patient treatment, unwilling to listen to what was being said by the ward staff, despite the fact that we're the ones caring for these people 24 hours a day and they only come in for a few hours (Nurse 7).

We're doing it this way and generally in the hierarchy of medicine or health care within the CF, it's going to be the physician who decides what's going on...certainly frustrated [me] when the physician doesn't really see your side of things at all (Nurse 2).

They [the physicians] had a discussion inside the OR and they didn't include the nurses in them, unfortunately, and so when they brought him out [from surgery], we were sort of all, Do you realize what you've done? (Nurse 3)

For the team and the CF nurses to have a positive experience during a deployment, team collaboration, and professional respect were crucial elements in the work and social aspects of a deployment/mission. When there was a lack of professionalism displayed by any of the team members towards the nurse or nurses, it insidiously affected all of the other contributing factors of moral distress for that individual or group of nurses. Subsequently, the moral impact experience was seen to go beyond just the individual CF nurse to affect others, the team, and the CF nurse's perceptions of the unit, CoC, and in some cases, the Canadian Forces as a whole.

The Development of Moral Distress

The consideration of options to address a stressor is a deliberational process (Folkman, 1997; Lazarus, 1999). However, the deliberational process does not mean that moral distress will

automatically occur every time an individual faces a dilemma, as it requires the individual to recognize the dilemma as a moral one. The data in this study revealed that individuality also influenced whether moral distress occurred, as some CF nurses viewed a specific situation as a moral dilemma while others did not. Moreover, if a moral action choice was made and blocked or stopped, the resulting moral distress experienced by the CF nurses was also individually based.

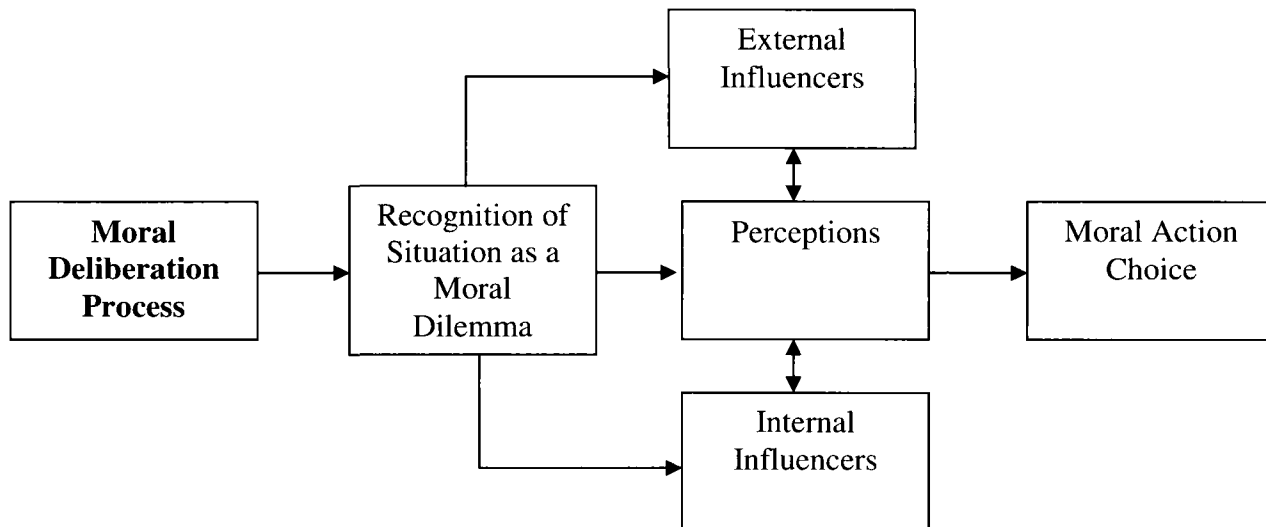
Phase 1: Moral Deliberation

Moral deliberation is the first phase in the moral distress process (See Figure 6). The term moral deliberation suggests that the decision process lay within the moral realm, when CF nurses recognized the situation as a moral dilemma. This process began with the CF nurses thinking carefully about the reasons for or against two or more moral options and ended when a single option was chosen. When CF nurses recognized the situation as a moral dilemma, the nurses then became unsure and tentative about what options were available to deal with the circumstances.

Once the moral options to address the situation became known to the CF nurses, these moral options were compared to each other by considering which option was felt to be the most morally correct and/or which option held more benefits than risks. Throughout this moral deliberation process, the unique environment influenced each step of this process. In Figure 6, some of the elements of this unique environment can be seen in the perceptions, external and internal elements highlighted in blue (See Appendix O for a detailed list). As a result, of this constant comparison of one to another, some moral options were discarded until a single moral action choice remained.

When considering the personal energy and personal cost expended by the CF nurses when deciding on a moral action choice, the importance of the moral deliberation process cannot be

underestimated. The data revealed that this process consistently affected the CF nurses and often resulted in some degree of personal cost to them when they implemented their moral action choice.



<p>EXTERNAL INFLUENCERS</p> <ul style="list-style-type: none"> • Environment • Reality of war & shifting care focus • Locus of control • Decisional power • Interprofessional respect • Logistics (resources, tempo) • Mandates and regulations • Host country infrastructure • Team cohesion 	<ul style="list-style-type: none"> • Amount of support (all levels) • Daily stressors • Clinical training/preparation • Type of patient • Time restraints • If I was in Canada • Military culture where <ul style="list-style-type: none"> ○ Silence = good soldier ○ Speaking out = disloyalty 	<p>PERCEPTIONS</p> <ul style="list-style-type: none"> • Amount of support • Career impact • What is the cost? • Is the cost worth it? • What choice can I live with? 	<p>INTERNAL INFLUENCERS</p> <ul style="list-style-type: none"> • Core values and beliefs • Congruent with organizations values and beliefs? • Fortitude • Willingness to tolerate situation • Career goals • Closeness to the situation • Expectations of roto, team
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Figure 6. Elements of the Unique Environment on Moral Deliberation Process.

In the following quote, a CF nurse captured how moral distress impacts more than one individual, the differences between nurses in the intensity of reactions to a given moral dilemma, and the influence of the distress on the individual’s energy levels:

A group of nurses, that were distressed by what happened, one more than the other, but it created such a bad atmosphere...when you decide to challenge something, it takes *a lot* of energy (Nurse 4).

This personal cost occurred as many CF nurses did not anticipate that their moral action choice would be blocked or they underestimated the intensive personal toll of their self-imposed inaction, particularly when their decisions were based upon experience, core values and beliefs, bioethical principles, and the CF Ethos and Values. Commonalities between Bioethical Principles and the CF Ethos and Values are described in Table 5.

Table 5

Bioethical Principles and CF Ethos

Bioethical Principles and Health Care	CF Ethos expected of CF members
Beneficence/Non-maleficence – Actions will do good /contributing factor no harm	Courage – Facing challenges with determination and strength of character
Respect for human dignity - Hinges on principles of self-determination (autonomy) and fidelity (truthfulness)	Honesty – Truthful in our decisions and actions Use of resources appropriately in the best interests of the mission
Justice – focuses mainly on the greatest good for the greatest number and fairness to all, particularly in the area of distributive justice in the allocation of resources	Integrity – Precedence given to ethical principles or obligations and not condoning unethical conduct Fairness – being just and equitable in our decisions and actions
Autonomy – the right to be informed and make a decision voluntarily without coercion	Loyalty – fulfilling of commitments that best serve Canada, Department of National Defence, and the CF
	Responsibility – accepting accountability for consequences of our actions and decisions while placing the welfare of others before ourselves

Note Table adapted from Holloway & Wheeler, 2002, National Defence, n d

The following quotes reflect the strong feelings experienced by how CF nurses when they felt that their core values were being challenged:

The one thing that bothered me the most was not being able to help civilians because our mandate for the mission was to take care of soldiers...we weren't there to do any humanitarian aid...it was really hard for me to see what the local population was going through and not being able to help at all (Nurse 8).

So that [speaking out] is very hard and to this day I still find, I still have mixed feelings about should I just ignore [as] there was only a few weeks to go. Would I do that again? But then if you don't say anything, I don't feel good. Because I know it's wrong. It's all about what's right, what's wrong (Nurse 4).

We have to do something because the [individual] was so disrespectful to us now and we feel so manipulated and betrayed, that unless we do something we're not helping ourselves. ...when I saw that our interactions at work were actually starting to affect patient care, I was thinking this has gone beyond just me being uncomfortable (Nurse 7).

When you knew that...resources could be better used on other individuals...I just don't think they [the physicians] were realizing that by doing that [intervention] they were perhaps taking away care that could be going to another individual. ...we were, as nurses, trying to advocate for almost other patients because they were taking up a bed that could've potentially saved someone else's life when you knew that individual [the patient] was going to die anyway (Nurse 2).

I did everything in my power to rectify the situation, and nothing was done...I lost faith in a system that I believe in to action something that was wrong (Nurse 6).

There are days when you are looking after critically ill detainees in one bed, while there is a critically ill Canadian soldier struggling for his life in the next bed, in the trauma bay...it's very difficult not to want to walk away Nurse 1).

The process of moral deliberation and subsequent moral distress not only left the CF nurses to deal with the moral impact from the identified causes of moral distress and the consequences of their choice, but also frequently led to consequences involving others directly (e.g., a group's moral action choice is blocked) or indirectly (e.g., rumours, perceptions of others). Please see Appendix N for a list of consequences of moral distress on the CF nurses. Having their principles and values challenged throughout the two-step process of moral distress exacted a significant toll on the CF nurses, particularly when these principles and values were continuously tested by the Unique Environment (See Figure 7).

Throughout this deliberation process, each CF nurse was influenced by the following factors: perception, external influencers, internal influencers, and the effects of the unique environment. These factors played a significant role in influencing the type of choices made by the individual CF nurse, further supporting the importance of individuality and why in certain situations one CF nurse may have felt moral distress and another CF nurse may have experienced no moral distress at all. The following section describes the process of moral deliberation and the factors of perception, external influencers, internal influencers, and features of the unique environment that influenced how the CF nurses progressed from their initial recognition of a moral dilemma to reaching a moral action choice and the potential results for them of their choice.

Moral Deliberation Process

The process of moral deliberation was influenced by an individual's perceptions, internal and external influencers and the elements of the Unique Environment, which included the four contributing factors of moral distress. Every one of these variables had an effect on each of the known moral options available to the CF nurse that were required to address the moral dilemma. The individual's influencers and perceptions also contained aspects of the unique environment (See Figure 6) but differed from the contributing factors. Once a situation was recognized as a moral dilemma, the contributing factor(s) affected the CF nurses by defining the moral dilemma, (i.e., the moral dilemma being faced was patient care delivery and/or chain-of-command). The perceptions and influencers (external and internal) were more specific in their effects on how the moral dilemma was appraised by the individual and the moral deliberation process, which ultimately involved a moral action choice. The moral action choice represented the most morally correct option for each individual CF nurse that maximized his/her chance of resolving the moral dilemma, while minimizing risk to the patient (if applicable), to them self, the team, and the unit. The CF nurse then deliberated as to whether or not to act on the chosen moral action choice. This deliberation process was further influenced by personal perceptions, the external and internal influencing factors and elements of the unique environment.

Perceptions

Perceptions refer to the opinions and views of the CF nurses that influenced their consideration of issues such as collegial and chain-of-command support, impact on their career and the team, and was based on their personal experiences, observation, assessment of the situation, and their thoughts of how other people might possibly react to their moral action choice. Participants frequently discussed their

perceptions of the people who would be supportive, the effect on their careers, the risk or benefit costs, and the choices that would be acceptable.

If you aspire to go higher [get promoted] then you'll have more tendency to be silent (Nurse 4).

A nurse is what I am, it's what I do...we give a lot of ourselves, our personality, not just nursing care...[but] we can all look ourselves in the mirror and know that the decisions that were made were the right decisions (Nurse 1).

If I found myself in the exact same situation, I would probably advocate the same way (Nurse 2).

I think I expressed myself and I think my expressions fell on deaf ears...[I] felt that I could do as much as I could (Nurse 6).

Influencing Factors

Influencers included both external (e.g., time, space, resources) and internal influencers. (e.g. fortitude, values and beliefs). External influencers (e.g. decisional power, team/intra-professional dynamics, mandates and regulations, and daily challenges) and internal influencers (e.g. commitment to one's core values and beliefs, fortitude, tolerance, and resources) were deliberated upon and weighted by the nurses, while influencing each moral option being considered for implementation to address the moral dilemma the CF nurse was experiencing. See Appendix O for a more detailed list of the external and internal influencers.

The Unique Environment of the Deployment Setting

The unique environment had a significant impact on the perceptions and influencers, and included the unique factors seen and experienced by the deployed CF nurses that were different when compared to their civilian colleagues working in civilian facilities in Canada (e.g., austere environment, constant threat of danger, poor amenities, etc.). As the central category, aspects of the Unique Environment such as the dangerous environment, atypical patient conditions (Fry et al, 2002), deployment readiness, resources and resupply were found to profoundly influence the CF nurses' experiences of moral distress.

The unique environment of deployed CF nurses also exposed them to differing daily challenges, such as: the loss of communications (telephone, email internet) with families or friends back in Canada, poor living conditions (noise, structural factors such as tents and high number of roommates in a small space), availability of basic amenities (lack of working showers, set time frames for and quality of meals), and being under constant threat of danger. Factors in the unique environment, such as finite resources and dangerous conditions, had a major affect on the moral options available in a war zone and the CF nurses' deliberation process, particularly in patient care delivery. The result of these effects frequently caused the CF nurses to choose a moral action choice that might not have been the moral action choice they would have preferred, or the most morally correct choice. Furthermore, some of the CF nurses still experienced a level of moral distress because this implemented moral action choice conflicted with their own personal values and beliefs. Frequently, their most preferred moral action choice was blocked by the circumstances found in the unique environment of a deployment setting.

The following quotes reflect some of the conflicts experienced by the CF nurses as a result of the unique environment that surrounded work or social relationships and the use of finite resources:

If you weren't able to get along with your colleagues, it was going to be a long miserable tour for you (Nurse 7).

The patient that is still alive, but you can't do enough to save them; yet you've got four more [patients] that you actually can save. So you can't save them (Nurse 3).

We were lucky that we didn't have a mass casualty that required us to use that bed. Because then we would have been in another moral dilemma trying to figure out who do you let go (Nurse 1).

When you have a patient there, you know that there's about a thousand more lined up outside that aren't receiving any sort of care (Nurse 2).

Results of Moral Action Choice

Once the CF nurses decided on a moral action choice, the data revealed that four results were possible: 1) the choice was blocked by outside factors (e.g., orders, time, resources), 2) the choice was blocked by the CF nurse alone (related to the lack of energy to fight or perceptions of potentially negative views of the nurse by others), 3) the choice was blocked, but the CF nurse was still satisfied with the outcomes, and 4) the choice was implemented and not blocked. While the results of this study found that CF nurses most often experienced moral distress if their moral action choice was blocked, the study also found that after a period of self-reflection, some CF nurses became satisfied with their moral action choice, despite it having been blocked. This was typically seen in situations that were beyond their control (e.g., type of casualties, poor resupply, restrictions on transfers) and consequently they could not have influenced the outcome, regardless of what they did or did not do. However, even with

this understanding, the CF nurses still experienced moral distress from their moral action choice being blocked. Their feelings are expressed in these quotes:

I did everything in my power to rectify the situation...and nothing was done...at the end of the day, there was nothing different that I could've done (Nurse 6).

If you kind of go on the official channels, it just makes things much more difficult, which it truly did. I feel that at the end of the day, I did everything that allows me to sleep at night (Nurse 7).

The mission is to preserve the fighting force [and] we have to be prepared to take multiple casualties of coalition soldiers at any time...[so] every single [local] patient that we advocated for; every patient that we let go; we know that it was the right decision (Nurse 1).

In situations where their moral action choices were blocked, the CF nurses described their feelings as being either positive or negative depending on what they did in the specific situation, their proximity and involvement, and who else was involved. For example, the CF nurses described their feelings as positive in situations where they felt they did everything possible, their proximity and level of involvement with the situation was minimal, and patients were not involved. Conversely, feelings were described as negative when the CF nurses felt they could have done more, were close and highly involved in the situation, and when the situation involved patients. Additional factors such as the congruency of the CF nurses' moral action choices with that of their colleagues, team, or unit's course of action, and/or if others disagreed, ignored, or trivialized the CF nurses' perspective on the situation further contributed to their negative feelings. These nurses described how they felt in these situations:

What do you do with something you know is not all right? Do you turn your head on the sideline?
(Nurse 4).

My opinion wasn't really counted (Nurse 3).

Overall, the nurses' satisfaction with their blocked moral action choice happened primarily after a long period of time had elapsed, and during their process of self-reflection. They now saw themselves as having done the best they could, despite the outcome.

Unlike the situation of having a moral action choice blocked by external factors or if the CF nurses felt that they did everything they could, CF nurses who personally chose not to implement their moral action choices did so for several possible reasons, to protect others (e.g., a colleague's failure to follow orders), when they believed their actions were not worth the cost (e.g. energy, deployment length, potential fracturing of relationships), or if they felt they could live with this less than optimal particular choice. When the CF nurses justified their self-imposed blocking or inaction as a means to minimize the moral impact on the team, CoC, and organization concerning the possible outcomes, their choice appeared to have a negative impact on them. This personal impact frequently resulted in the expression of feelings of guilt, regret, self-loathing, emotional withdrawal, and blaming themselves for not having the courage to take action. Self-imposed blocking often resulted with nurses implementing drastic actions such as changing and/or compromising personal core values and beliefs, leaving the nursing profession, leaving the military and/or losing their sense of self. As one nurse described:

I tried to talk to him at first but then I just got to the point where I would avoid him... I would do whatever I could to not have anything to do with him...it can still bring me to tears because I

just...feel so frustrated because I...didn't handle it well and... to...you know, stand up to him...I should've told him [off]. But I thought that just makes me no better than him (Nurse 9).

Some nurses reconsidered their original moral action choice depending on who was affected (e.g. patient or health care provider), what they were willing to tolerate, and what decision was reasonable. As illustrated in the following quote, in some situations the process of reconsideration and subsequent implementation of a previously self-imposed blocked moral action choice happened because of a nurse's sense of self-preservation, and not to address a moral dilemma:

We have to do something because they are so disrespectful to us now and we feel so manipulated and so betrayed, that unless we do something, and we're not helping ourselves to, you know, to...deal with the situation" (Nurse 6).

When CF nurses chose not to act, their decisions were frequently based on their perceptions of the possible outcomes and repercussions if they did act, for themselves, the team, and their relationships with others within the team. Their perceptions were often based on personal past experiences and the dynamics of the current health care team, as illustrated in the following quote:

It's only in hindsight that I think, like, jeez, should I really have accepted that? (Nurse 4).

The CF nurses' self-imposed blocking of the moral action choices sometimes led to feelings of self-blame, guilt, and self-doubt for failing themselves (compromising core values and beliefs) and others (advocating for patients or peers/subordinates); as the actual moral dilemma could have been

resolved if they had decided to act. This nurse describes how her inability to act affected her, and the strong feelings she is still experiencing:

Time passes and I can still feel this anger that it happened and that I didn't do anything and the sadness that I still regret [not standing up] more than anything (Nurse 9).

The intensity of the emotions experienced by the CF nurses is reflected in this nurse's description of how her core values and beliefs were challenged:

The hell with appropriate withdrawal of care. The hell with the Geneva Convention. The hell with...any...ethics or morals or anything that I truly do believe in. I wanted to unplug his machine (Nurse 1).

Phase 2: Moral Impact

Moral impact was the phase that followed the process of moral deliberation. This phase began once the CF nurses' moral action choices were either blocked/stopped or they personally chose not to act on their moral action choice (See Figure 7).

However, there were instances where the CF nurses may have chosen an action and, after having reflected on the choice made, felt they had made a bad decision. In these cases, the data did not reveal that these choices lead to moral distress, as most CF nurses felt justified with their implemented moral action choices despite the outcome. These nurses described this justification in the following way:

I felt at the end of the day; I did everything that allows me to sleep at night. (Nurse 7).

If I found myself in the exact same situation, I would probably advocate the exact same way (Nurse 2).

We did what had to be done (Nurse 4).

I know that it was the right thing to do by letting someone else take care of him (Nurse 1).

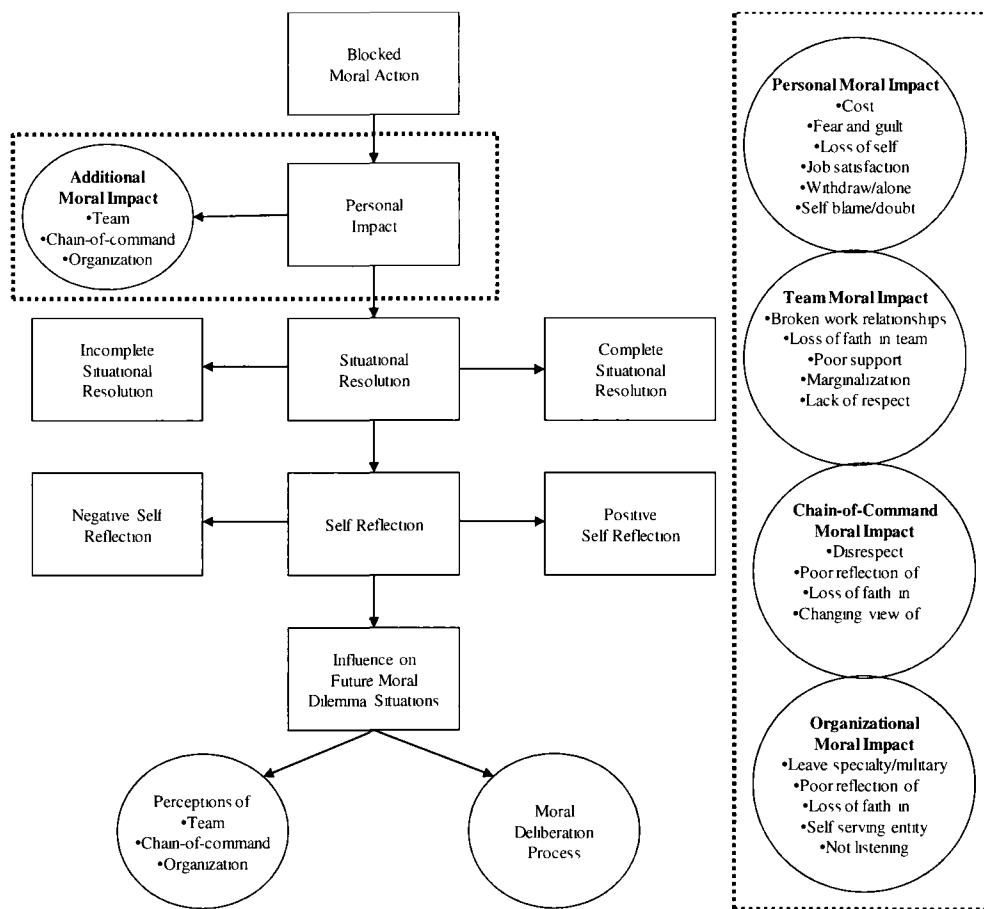


Figure 7. The Moral Impact Process after a blocked moral action. Examples of moral impact are expanded from the flow chart and illustrated on the side.

For those moral action choices that resulted in blocked/stopped action or no action taken, the impact of moral distress on the CF nurses occurred at four levels 1 Personal, 2 Team, 3 Chain-of-command, and 4 Organizational Table 8 describes the common outcomes of moral impact on each of these levels The nurses’ quotes that appear within Table 6 illustrate the experiences of the nurses at each of these levels

Table 6

Levels of Moral Impact

Level	Common Outcomes and Supporting Data
Personal	<ul style="list-style-type: none"> • Fear, withdrawal, self-blame, and doubt <p>You know what? I’m empty I don’t have anything left to give I’m this empty vessel walking around and it took me a long time to feel like myself again (CF nurse 1)</p>
Team	<ul style="list-style-type: none"> • Broken work relationships, poor support and respect, marginalization <p>Can you imagine working, being in the same compound as someone you reported? Can you imagine the tension, the atmosphere? whew! (CF nurse 4)</p>
CoC	<ul style="list-style-type: none"> • Disrespect, loss of faith in , poor reflection of leadership <p>when nothing was done, I just couldn’t look at my CO the same way I just thought, How weak! Why aren’t you doing something about this? (CF nurse 9)</p>
Organization	<ul style="list-style-type: none"> • Loss of personnel, self-serving, non-caring, not listening <p>And how does that make for a better military? How does that make for a better branch? How does that breathe faith within the ranks? (CF nurse 6)</p>

When the moral impact involved the team, chain-of-command, and the organization in the blocking of the CF nurses’ moral action choices, and particularly when issues such as lack of support, inaction and lack of change in policy were outcomes of the moral dilemma, the data illustrated how the CF nurses sometimes changed their views with respect to these groups

Sometimes, even the CF nurses’ desire to remain in the military and/or the nursing discipline altogether was challenged This nurse describes her feelings

I've become very disillusioned with the [medical] branch itself...I'm kinda sitting on the fence right now on whether I may or may not continue on with the military (Nurse 7).

The process of moral impact on the CF nurses did not end with a blocked moral action choice or their decision not to act on a moral action choice. The subsequent impact also included successive stages of situational resolution (complete or incomplete) and self-reflection (positive or negative). The final phase of the moral impact process revealed how previous stages of moral impact, situational resolution, and self-reflection could have a significant effect on CF nurses' perceptions of themselves, their team, CoC and organization, and influenced their future moral deliberation processes when faced with new or similar moral dilemma situations.

Situational resolution and self-reflection.

The findings of this study revealed that reactive distress consisted of a process of situational resolution and self-reflection that occurred as the CF nurses tried to cope or make sense of the outcomes of their moral action choices. Mechanisms of situational resolution and self-reflection were employed by the CF nurses that enabled them to move past the moral distress experience towards acceptance, reconciliation, self-protection, and the ability to cope with the outcomes. Situational resolution occurred first as the CF nurses struggled to understand their emotions, relationships, and ability to function as nurses and individuals. Situational resolution was followed by self-reflection, which was an ongoing process used by the CF nurses to gain meaning and provide justification for their choices, and the repercussions of those choices. As the CF nurses moved through these stages, the data illustrated that situational resolution may or may not have occurred, and that the process of self-reflection could be

perceived as being negative or positive. This negative or positive process of self-resolution and self-reflection revealed is reflected by the nurses in the following quotes:

We all can look ourselves in the mirror and know that the decisions that were made were the right decisions (Nurse 1).

When I saw that our interactions at work were actually starting to affect patient care, then I was sort of thinking, well, this has gone *beyond* just me being uncomfortable (Nurse 7).

As they moved through the two phases of the Moral Distress Model, the outcomes of this moral impact process were found to have considerable influence on the CF nurses' future experiences with moral dilemmas, their ability to deliberate and choose a moral action choice, and their perceptions of themselves, the team, chain-of-command, and organization. This happened regardless of whether complete or incomplete situational resolution occurred or whether the CF nurses came away from the situation feeling positive or negative as a result of self-reflection. The following quotations from the nurses illustrate the considerable influence their experiences had on them and how their present perceptions could shape their future responses to similar situations, and ultimately, themselves:

I fear some day, I'll have to run into him again...so, yeah, I should have been able to do something (Nurse 9).

Because when you decide to speak out, things don't get better (Nurse 4).

It affected their morale and their sense of well-being so *dramatically* that it changed the way they acted on a day-to-day basis...it brought them down...they felt manipulated and abused (Nurse 6).

There's two parts that affect me the most, one was the failure in senior leadership to act...and two...what that did to the three nurses that were brave enough to stand up for what was right...what is their belief now (Nurse 6)?

I guess my expectation is that nothing will happen, which is quite disappointing, which is certainly something that's...very detrimental to our branch (Nurse 7).

Summary

Based on the findings of this study, a new two-phase Moral Distress Model was developed consisting of two phases: Phase 1: Moral Deliberation and Phase 2: Moral Impact. The findings of this study suggest that moral distress should be considered as an “all encompassing” phenomenon composed of a two-phased process consisting of moral deliberation *and* moral impact, with each phase influenced in its entirety by the Unique Environment of a combat or humanitarian mission. The effects of the Unique Environment on the CF nurses during their moral deliberation process were as demanding and stressful for them as the moral impact experienced from moral distress alone. In addition, when considering the personal energy expended by the CF nurses when deciding on a moral action choice, the importance of the moral deliberation process cannot be underestimated. The data revealed that this process consistently impacted the CF nurses and often resulted in some degree of personal emotional cost to them when they implemented their moral action choice.

In summary, the new two-phased model outlines the processes involved in the development of moral distress, and highlights the continuous and significant influence of the Unique Environment on all aspects of the moral deliberation and moral impact process on deployed CF nurses practicing within the context of a combat or humanitarian mission.

Chapter 5 – Discussion

This chapter will provide an in-depth discussion of the findings of the study. An overview of the new moral distress model is presented, followed by a discussion of the relationship between moral deliberation, moral impact and moral distress, and the impact of the deployed military environment on the nursing population studied. The implications of the findings of the study for both nursing and military practice, limitations of the study and recommendations for future research are also presented.

A New Moral Distress Model

The findings from this study led to the development of a new Moral Distress Model, which reflected the military context of deployed CF nurses through its central category of “Unique Environment” and the continuous and significant influence of this category on all phases of the model. This model suggests that moral distress is an “all encompassing” phenomenon that includes a two-phased process: moral deliberation and moral impact. This two-phased process occurs in response to four main causes of moral distress: issues around patient care delivery, chain-of-command (CoC), lack of moral preparation and training, and lack of professionalism.

The study’s model resembles previous civilian studies on both moral distress and stress in which decisional issues or influencers affect the decided course of action and the consequences of acting or not acting on the choice. For example, Fry, Harvey, Hurley, & Foley’s (2002) study of US military nurses’ stories of moral distress and Folkman’s (1997) stress model describe how an individual will go through phases of arousal (challenge), appraisal (defining situation and consideration of resources or benefits and risks), and judgement (the decision). However, this study proposes that moral distress is actually a two-phased phenomenon that includes both the decision process (moral deliberation) and the consequences surrounding the CF nurses’ decisions to act or not on their moral action choice (moral impact).

Moreover, this model also illustrates how moral impact is clearly linked to future moral dilemmas by positively or negatively affecting the moral deliberation process. This understanding suggests that when multiple negative moral impact outcomes occur from subsequent moral dilemmas, these outcomes linger and may predispose the CF nurses to a crisis state (Lavee, McCubbin, & Patterson, 1985). For example, because of the military culture, many of the CF nurses chose not to act on their moral action choices, and the moral dilemma(s) remained unresolved for lengthy periods. The cumulative effect of their decisions not to act created a significant level of constant moral distress (crisis state) for the nurses, and influenced how they dealt with future moral dilemmas.

A crisis state can be defined as a period during which individuals no longer have the resources, both internal and external, to deal with a stressful situation (Lavee et al, 1985). By virtue of their inactions, the CF nurses placed themselves in an unending loop of moral deliberation (to act or not to act) to moral impact (no resolution and self-depreciating reflection) and back again. This loop was clearly illustrated in the Moral Distress Model of this study where the loop continued to increasingly challenge the CF military nurses' abilities to access their resources and personal reserves to deal with unresolved dilemmas or new moral dilemmas (Boss, 1989; Lavee et al, 1985; Lazarus, 1999; Wilkinson, 1987/88). For example, Nurse 9 described the nurses' difficulties with their chain-of-command, where their efforts to address the moral distress situation were blocked. As the situation continued to occur frequently, the nurses became so fearful, that they had difficulty functioning, which ultimately led to this individual quitting the CF.

The Link between Moral Deliberation, Moral Impact and Moral Distress

Further analysis of the data led to the development of the Moral Distress Model. The relationship between moral deliberation, moral impact and moral distress became more apparent and was integrated

into the model. This direct link between moral deliberation and moral impact presented a new understanding of moral distress when compared to previous models, which focused only on reflecting how moral distress resulted from blocked action, (AACN, 2006a; Elpern, 2005; Fry et al, 2002; Gutierrez, 2005; Nathaniel, 2006; Wilkinson, 1987/88). Badger & O'Connor's (2006) study also focussed on the aspect of blocked action, which they termed as "moral discord". The findings in this study indicated that the concept of moral distress encompassed more than just blocked action and lingering effects (*moral impact*), by suggesting that the development of moral distress included two processes *moral deliberation* (decision) and *moral impact* (effect). This new understanding of moral distress suggests that the moral distress one experiences deliberating on a moral action choice can be just as distressing as the moral distress one feels when the moral action choice is blocked or stopped.

Models of stress, such as the ABC-X Model (Boss, 1988), Double ABC-X Model (Lavee et al., 1985), and Cognitive Appraisal Model (Folkman, 1997; Lazarus, 1999), discuss the link between the effect of past experiences and unresolved dilemmas on the person's current and future deliberation processes and decisions. This link is illustrated within their respective models (See Figure 3 on page 15). These studies on stress have demonstrated how this accumulation of negative energy predisposes one to a higher level of stress sensitivity, lower coping capabilities, and/or crisis. These models also suggest this predisposed higher level occurs as an individual's resources to cope with additional or new stressors are challenged by negative experiences and unresolved stressors.

The model developed from this study supports past models of moral distress *and* stress in that one's past experiences and unresolved issues are shown to impact future experiences on how a situation is recognized as a moral dilemma, what the individual will do to address the situation, and the results from dealing with or not dealing with the moral dilemma. While the aspects of lingering issues on future moral dilemmas are discussed in civilian literature, the findings of those studies focused primarily on the

current definition of moral distress. This definition involves choosing the best moral option for the individual to address a moral dilemma with this moral option being stopped or blocked by resources, organizational policies and procedures, facility and medical orders, and time. (Jameton, 1993; Nathaniel, 2006; Wilkinson, 1987/88).

The process by which the CF nurses experienced moral distress was understood to go beyond the blockage of a moral action choice, or inaction, which Jameton (1993) called “initial distress”, to where the process of situational resolution or situational acceptance and self-reflection occurred. This process was understood to play a key role in the development of lingering effects, influencing the nurses’ future responses to moral dilemmas. Lingering effects are those past positive and negative experiences of moral distress, where the resulting outcome of these experiences “linger” and go on to affect the individual in future moral dilemmas. In civilian studies, lingering effects have been described by Jameton (1993) as reactive distress, by Webster & Baylis (2000) as moral residue, and by Nathaniel (2006) as moral reckoning. Although Wilkinson (1997/98) did not suggest a specific term for lingering effects, she described how the negative feelings and psychological disequilibrium caused by moral distress were linked with an individual’s past experiences and the outcomes to moral dilemmas.

In this study, the link of past experiences to future moral deliberation revealed that the development of moral distress was not dependent solely on whether a moral action choice was blocked or stopped, but also included the stress or distress of the deliberation process. The deliberation process was influenced by the nurses’ past experiences, the real and perceived external and internal influencers, and the effects of the “Unique Environment”. Ultimately, the lingering effects together with these factors influenced which moral action choice was chosen and whether it was acted on or not. Furthermore, findings in this study revealed that the impact of the self-blocking of a moral action choice on the nurses was significant, and therefore warranted inclusion in the new moral distress model.

Expanding the Concept of Moral Distress

One of the implications of this study's findings relates to the concept of moral distress itself and how it has been defined in the current literature (Lützn, Cronqvist, Magnusson, & Andersson, 2003; McCarthy & Deady, 2008). While Jameton's (1993) definition is the one most often recognized as the standard, many others have introduced new terms that either replace the term moral distress itself by referring to it as: moral stress (Lützn et al, 2003), moral discord (Badger & O'Connor, 2006) and moral reckoning (Nathaniel, 2006); or have expanded the concept of moral distress to include other concepts within it such as: moral residue (Webster & Baylis, 2000); moral sensitivity (Lützn et al, 2003), and psychological disequilibrium and moral outrage (Wilkinson, 1987/88). The findings of this study add to this understanding by suggesting that moral distress is more than the result of a blocked moral action choice, and is made up of two distinct phases: moral deliberation and moral impact.

The use of differing terms and models of moral distress led McCarthy & Deady (2008) to raise the question of whether moral distress is in and of itself a concept of cause and effect or if it serves as a comprehensive concept that includes all of the above terms, negative *and* positive outcomes, and/or whether a moral decision is based on the individual's moral beliefs or is an act of self-preservation. Findings of this study strongly suggest that moral distress is a comprehensive concept that includes a two-phased process with negative and positive outcomes. Findings also suggest, as described in the situations where some CF nurses could no longer cope with their original or ongoing choice to not employ their moral action choice, that a moral action choice is influenced by one's moral beliefs and can also frequently be an act of self-preservation.

In the Lützn et al (2003) review of current nursing literature on moral distress, they hypothesized that stress has a moral component. They termed this as "moral stress" that arises from moral sensitivity to the inability to employ their moral option, but also included "the understanding of

stress as an individual everyday experience” (p. 318) to a stimulus and the individual’s response. This study supports the individuality of one’s response to a stimulus, because of stressors or daily challenges (Lazarus, 1999) and the unique environment. Particularly on how the CF nurse will respond to a moral dilemma situation by their perceptions, influencers, and demands to address the moral dilemma, which is a process similar to that illustrated in stress models (Folkman, 1997; Lavee et al, 1985; Lazarus, 1999). In addition, this study supports current literature in the recognition that the term “moral distress” can be negative or positive/satisfactory to the individual (Lütznén et al, 2003; McCarthy & Deady, 2008; Nathaniel, 2006; Webster & Baylis, 2000) as some CF nurses did feel justified, satisfied, and confident that the decisions they had made were right, given the situation and any situational restraints, even if their moral action choices were blocked in the end.

The Impact of the Deployed Military Environment

Work and living conditions

In the only other study to date that has examined the development of moral distress and military nurses, Fry et al’s (2002) study of US Military Nurses noted the significance of the unique military environment and military culture, in comparison to the civilian context. Similar to Fry et al’s (2002) findings, this study on CF nurses also revealed that combat or humanitarian missions placed the CF nurses in environments that were austere, harsh and dangerous. For example, the ongoing daily challenges (Lazarus, 1999) that these nurses experienced, such as a heightened sense of danger (rocket attacks), inadequate sleep and rest, lack of or poor amenities (showers), excessive and continuous noise, limited access to normal support structures (family, trusted friends), and restricted personal movement, were constant stressors experienced by the CF nurse that were not generally noted in the current literature on civilian nurses.

The uniqueness of the CF nurses' deployed environment was significant, as it placed the CF nurse in situations where they could be more susceptible to moral distress. While acknowledging a number of similarities between the findings in civilian literature and this study, it was the *continuous* influence of this study's central code "Unique Environment" on *every part* of the moral deliberation and impact processes which revealed that the "Unique Environment" was the key difference between the findings of this study and those of nurses who practice in a civilian context.

Working in a team

Many of the elements of positive team collaboration from civilian literature focus on relationships, common goals, role definition, collaborative behaviour, and shared decision making (Herbert, 2005; Gratton & Erickson, 2007; Xyrichis & Ream, 2007). While the findings of this study supported the value of positive team collaboration, it is suggested that for deployed CF nurses, effective team collaboration was essential for them to have a successful mission. For example, although Gratton & Erikson (2007) recognized the need for fostering a strong sense of community outside of the workplace, their suggestions for how to achieve this were mainly related to an "event" within a short timeframe (e.g., during work hours), which does not take into consideration the type of team collaboration required during a deployment. In a deployed setting, positive team collaboration must go beyond an event and encompass all aspects of life (e.g., work, support, and social relationships) over each complete day for an extended number of months to gain this strong sense of community.

Negative deployment experiences associated with poor team relationships and functioning were significant for the CF nurses. These lingering effects affected the CF nurses' current and future mental health, performance and relationships, and influenced their retention within the nursing branch or Canadian Forces.

Ethical principles and the realities of war

The greatest influence the environment had on the CF military nurse lay in the realities of war (e.g., polytrauma, poor infrastructure in the country) and its influence on the types and numbers of patients, seriousness of their injuries, entitlement to and duration of health care, and most importantly, the impact these had on a *finite* amount of resources. This was described in the findings as resource triage and illustrates a shift in the bioethical influences (e.g., non-maleficence, beneficence, fidelity, autonomy) on health care delivery in situations where the highest emphasis was frequently placed on distributive justice.

Distributive justice emphasizes that the distribution of finite resources is meted out in such a way that it does the greatest good for the greatest number (Gross, 2004, Gutierrez, 2005). In the deployment setting, the significance of distributive justice was dependent on the mandate (who would have been entitled to care) and the type of mission (combat or humanitarian). In a humanitarian mission, the above definition of distributive justice applied because the patients primarily treated would have been civilians. However, in a combat mission distributive justice was done for the greatest good, but may not have always been done for the greatest number. As a result, CF military nurses often developed a depersonalized view of the civilian patients they cared for due to the reality of what the nurses could do and what they actually did. This view was more evident when it was known that the civilian patient had killed or injured Canadian soldiers or children, and/or the patient was abusive (physically/verbally) to the CF military nurses. Civilian studies have also shown that nurses withdraw, minimize contact, and become more impersonal in the delivery of patient care as a result of moral distress. For example, a study by Gutierrez (2005) on Critical Care Nurses' perceptions of and responses to moral distress, found that 58% of the participants requested to not care for the patient, 41% withdrew and had decreased interaction with their patients, and 34% limited and depersonalized their patient care delivery. While

this study revealed similar findings, the intense negative emotions expressed by the CF nurses in their interviews towards the local civilian patients were a reflection of the realities of war, and its influence on the types of patients cared for, military mandates and rules, and limited resources.

The Individuality of the Process

Each of the CF military nurses experienced moral distress differently, supporting the findings of studies conducted with other nursing populations, which indicated that moral distress was individually based, dependent on perceptions, personal characteristics, past experiences, closeness to the situation or patient, and sensitivity (Austin, Lerner, Goldberg, Burgum, & Johnson, 2005; Lützén et al, 2003; McCarthy & Dedy, 2008; Wilkinson, 1987/88). The CF nurses' individual perceptions of moral distress were influenced by; the type of situation, who was involved (e.g. patient, team, CoC), and stressors (daily challenges) such as: amount of sleep, space, and work tempo, level of positive socialization, and quality of amenities, living quarters, and food. However, additional personal factors such as feeling a sense of responsibility to the situation, locus of control, coping skills, personal characteristics (e.g., fortitude, resilience, integrity, sensitivity), expectations, perceptions of others or the situation, moral residue (CNA, 2003; Lützén et al, 2003; Webster & Baylis, 2000; Wilkinson, 1987/88), also influenced whether or not the situation was perceived as a moral dilemma by the CF military nurses. Similar to findings of studies conducted on the development of stress of families and random participants (Boss, 1989; Folkman, 1997; Lazarus, 1999; Lavee et al, 1985), the nurses' personal accumulation of unresolved moral distress and/or the consecutive occurrence of moral dilemmas also affected their responses to subsequent moral dilemmas. From this study, these effects were particularly seen in those moral dilemmas that involved patient health care delivery, organizational conflicts, power imbalances and impact on patient care, outcomes also reported in civilian literature (AACN, 2006b; Austin et al,

2005; Corley, Minick, Elswick, & Jacobs, 2005; Erlen, 2001; Gutierrez, 2005; Lütznén et al, 2003; Meltzer & Huckabay, 2004; Oberle & Hughes, 2001).

The Military Culture – Special Considerations

Issues of Power - The Physician and Nurse Dynamic

Findings in this study indicated that the physician or nurse dynamic during a deployment was highlighted around differing views of how care should be delivered (e.g., advocating care, ongoing treatment with no real benefits versus trying to save everyone by any means), the hierarchical nature of the military (i.e., physicians frequently have higher ranks than nurses), and professional relationships between the disciplines. When exploring the working relationships between nurses and physicians, civilian studies have also found that there are issues and differences between physicians and nurses when dealing with ethical issues related to end-of-life decisions. For example, Oberle & Hughes (2001) found that differences in professional roles influenced end-of-life decisions (e.g., the patient advocacy focus in nursing versus the save or cure focus of physicians). Furthermore, civilian studies have found that the training and socialization of each discipline influenced their views of a health care situation, and subsequently the decisions that practitioners were required to make (Hall, 2005). For example, a study by Whitehead, (2007) on physician and collaboration suggested inter-professional education as a means to engage in collaborative practice. The findings illustrate how issues, such as sense of authority for medical decision-making, have led to the reluctance of physicians to collaborate on medical decisions with other health care providers in some situations. The results of this study on CF nurses, concurs that when differing views did exist, between the nurse and physician, interdisciplinary conflict generally occurred between these two disciplines because the reasons for the decision made by the physician or nurse were misunderstood by the other (Hall, 2005).

Studies that explored the professional dynamic between physicians and nurses in the civilian context found that many nurses perceived themselves as not being respected, “not being heard” or included in the decision making process, and of having to prove themselves clinically (Austin et al, 2005; Erlen & Sereika, 1997, Gutierrez, 2005; Sudin-Huard & Fahy, 1999; Wilkinson 1987/88). While the results of this study support these findings, an important variable existed in the consideration of hierarchy and power. In a deployed setting, the power imbalance went beyond the physician or nurse work dynamic in the day-to-day delivery of health care, and included what one CF military nurse defined as “the rank dynamic”. Military physicians were often senior in rank or held senior positions (e.g., Commanding Officer), and were responsible for giving orders, maintaining discipline, and enforcing regulations. As a result, the rank structure in the military provided a level of additional power to the physicians. From the CF nurses’ stories, this imposition of an order occurred mainly surrounding issues of failing to enforce regulations, patient autonomy, and resource triage. Consequently, the majority of the moral dilemmas, causing moral distress, were often a result of issues concerning power imbalances based on both the physician or nurse professional dynamic and the physician or nurse rank dynamic.

Implications for the Military Establishment

The results of this study revealed the potential impact of moral distress on the individual, military organization, and society (see Table 7) and the implications for nursing within the military context. Studies of civilian nurses have shown that moral distress leads to outcomes such as feelings of frustration and guilt, pain, sleep dysfunctions, physical withdrawal from family/friends, reluctance to care, and professional withdrawal from other team members (Corely, 2002; Gutierrez, 2005; Wilkinson, 1987/88). As the findings of this study revealed similar outcomes for CF nurses, it is recommended that

the Health Services Branch employ management strategies to prevent and/or mitigate moral distress that may be experienced by the members of the health care team.

Table 7

Suggested Impact of Moral Distress

Level Affected	Cost(s)
Individual	<ul style="list-style-type: none"> • Physical, emotional, behavioural, and spiritual distress • Poor physical care • Withdrawal from patient care • Decreased capacity to care • Quitting the organization or discipline • Lingering effects
Organization	<ul style="list-style-type: none"> • Staff shortages (both nurses /soldiers not returning to active duty and the associated costs) • Difficulty retaining and recruiting nurses • Decreased morale • Increased chances of conflict related to poor work environment, staff mix will not be changed • Increased sick time (short and long term)
Society	<ul style="list-style-type: none"> • Increased need to use incentives to recruit staff • Increased costs to treat physical/psychological consequences of moral distress • If shortage great enough, could possibly affect type of tour/missions the military participates in as representatives of their country

Note Table adapted from AACN, 2006a, 2006b, CNA, 2003, Gutierrez, 2005, Wilkinson, 1987/88.

General strategies the CF Health Services Branch could consider in addressing moral distress can be based on recommendations from the civilian nursing literature. These recommendations include the importance of an interdisciplinary or collaborative approach, educating CF nurses in nursing ethics, nurses mentoring nurses and other team members, continued education in nursing ethics, creating an ethical work environment (Corley et al, 2005), and having nurses engage in open dialogue and provide

input on ethics committees (AACNA; b, 2006, Austin et al, 2005; Badger & O'Connor, 2006; Corley et al, 2005; Erlen, 2001; Gutierrez, 2005; Hamric, 2000; Wilkinson, 1987/88). Additional specific recommendations that apply to the military context include strategies such as raising CoC's awareness of the importance of addressing and following through on staff complaints and/or concerns related to moral issues, pre-deployment training, continuing staff education, and creating opportunities to foster team collaboration during deployment. These recommendations are presented in the following section and conclude with suggestions surrounding who should be responsible for implementing them.

Preparing the Team at the Pre Deployment Stage

The unique environment that all health care providers face during a deployment cannot be viewed solely in terms of work relationships, as it also includes social and supportive relationships. This reality further emphasizes the need for all health care professionals to collaborate prior to a deployment to build a strong sense of community (Gratton & Erikson, 2007). It is suggested that a key component of a successful mission may lie in the preparation of the deployed health care team (i.e., the Health Services Support Unit) for clinical, operational, and social moral dilemmas frequently encountered in the deployed setting. To foster a work environment that emphasizes collaborative and ethical approaches to a moral dilemma, recommendations for pre-deployment training include:

- Facilitated and open discussions in a relaxed environment with no time pressures or interruptions to enable team members to review and discuss moral dilemmas in a collaborative manner. An ethical work environment exists when ethical values (e.g., bioethics) guide professional behaviour including ethical treatment of and decisions surrounding treatment of patients (Corley et al, 2005);

- Discussions that focus on moral dilemmas, which may impact clinical, operational and social aspects of a deployment at a general (e.g., contravention of regulations, rank dynamics) and specific level (e.g., entitlement to care, living quarters);
- A collaborative team approach in dealing with morally challenging issues is important to integrate into pre-deployment training, as moral dilemmas may involve more than just the individual nurse and can negatively affect all levels of the deployed unit. Pre-deployment discussions, including role playing, of how the team will respond and support each other in morally challenging situations would allow for the team members to better prepare themselves for the real decisions that affect the delivery of health care influenced by the availability of resources and the number of current patients and new casualties.

Staff Education for Health Care Providers.

Findings of this study revealed that for CF nurses, lack of training in dealing with moral dilemmas was a contributing factor for the development of moral distress. This understanding suggests that in addition to pre-deployment training, staff education for nurses and health care team members within the military may be an important strategy in preventing and/or mitigating moral distress (AACN, 2006a; Badger & O'Connor, 2006; Corley, 2002; Hamric, 2000). Specific recommendations include:

- Educating newly graduated/recruited CF nurses during their military phase training (e.g., Basic Nursing Officer Course) about recognizing and coping with moral distress;
- Requiring additional training sessions on ethics and health care (bioethics) for all members of the health care team, which can be implemented at multiple levels – the unit, the base, regionally, or nationally;

- Providing CF nurses and team members with information on strategies to cope with moral distress, such as journaling (Ihlenfeld, 2004). The mentoring of newly deployed nurses by those with deployment experience can also provide mutual benefits.
- Developing practice guidelines in current Standard Operating Procedures (i.e., equivalent to Policies and Procedures' Manuals found in civilian facilities) on morally challenging situations relevant to the deployment context.

Creating opportunities to foster collaboration during a deployment.

Knowledge gained from this study can also be applied by the military organisation in the development of interventions that may manage or mitigate the effects of moral distress while the CF health care team is deployed. Through the development of a collaborative team approach during pre-deployment training and building on it throughout a deployment towards addressing complex issues, the following strategies can foster openness, team collaboration, and mutual support when dealing with moral dilemmas:

- Inter-professional ethics boards (meetings) to review decisions made in response to moral dilemmas and their subsequent impact (e.g., shifting a patient's care to palliation, based on distributive justice). These meetings should include the health care providers directly involved and representatives from each discipline and be conducted in an open format, regardless of rank;
- In-service teaching sessions designated to increase knowledge and skills through education and/or scenario role-play on topics related to morally challenging situations;

- Debriefing sessions after a traumatic event and/or multi-disciplinary ethical board meetings that involve nurses and other disciplines, to determine if any changes are required in the delivery of health care, particularly with civilian or local national patients;
- Creation of “town-halls”, or open forums for medical personnel to discuss points of interest/concerns related to common moral dilemmas all staff will face on their deployment, and how the application of bioethical principles will shift from their application in Canada to application in a combat and humanitarian mission (Gross, 2004);
- Supporting and facilitating the development of social events (e.g., athletic teams, holiday celebrations) that build team spirit and facilitate collaboration.

Responsibility for Implementation

The AACN (2006a) asserted, “every nurse and every employer are responsible for implementing programs to address and mitigate the harmful effects of moral distress in the pursuit of creating a healthy work environment” (§6). Similarly, responsibility for the implementation of the aforementioned strategies to deal with moral distress within the deployed setting should involve the engagement and collaboration of nurses, members of the health care teams, and the CF organization at both formal and informal levels.

The formal level involves the development of instructional programs to educate CF personnel about moral distress, its process and effects, and mitigating strategies (e.g., sharing, ethical boards, role-playing), and methods to evaluate the effects of these strategies. This training plan would be developed by the CF Health Services and require the approval of higher authority (e.g., Surgeon General), before the course(s) could be implemented. The training could occur at any time in an individual’s career and implemented at the unit level (e.g., professional development, in-services), regional level (e.g.,

recertification, continuing medical education) or organizational level (e.g., Basic Nursing Officer Course).

The informal level involves the health care team about to be deployed and the CF nurses. The Commanding Officer (CO) has an important role in facilitating and supporting the development of pre-deployment discussion groups and role-playing activities on common moral dilemmas faced during deployment. In addition, CF nurses who have previously been deployed can mentor other CF nurses and members of the health care team who have never deployed before by sharing personal experiences of moral distress and strategies that could assist in coping with challenging moral situations.

Implications for Research

This was the first study conducted to explore the unique working conditions of deployed CF nurses, to better understand how moral distress is experienced within this population. Important questions remain and can provide direction for additional research on the subject of moral distress. For example, further research on other health care team members' (e.g. physicians, medical technicians, mental health workers, pharmacists) experiences of moral distress is suggested to better understand their respective moral distress process and contributing factors, as elements of the unique environment, and its influence on their experiences when dealing with moral dilemmas. This information can provide understanding and insight to health care disciplines when facing similar moral dilemmas during a deployment as a collaborative team. This knowledge can also be used by the military organization to develop and/or contribute to an environment of collaborative decision making, with enhanced job satisfaction and patient care (Hall, 2005; Oberle & Hughes; Whitehead, 2007; Xyrichis & Ream, 2007).

To provide a broader understanding of moral distress and its effect on deployed nurses, further research is also required to determine the influence of specific support systems and variables such as

age, gender, years in nursing, recent versus older deployments, and the frequency and type of deployment (combat, humanitarian) on the CF nurses' experience of moral distress. Studies that employ different methodologies, inclusion criteria (e.g., enrolment dependent on time since last deployment), and/or approaches to data collection (emic/etic) have the potential to reveal valuable information that can be used by the military organization to develop interventions tailored to the needs of specific populations of health care personnel.

In this study, recommendations for the military organization focused on the importance of developing strategies and interventions that support a collaborative and ethical workplace. One of these suggestions included providing CF nurses and other team members with strategies to enhance their ability to cope with the significant effects of moral distress. As further research is required to determine the effectiveness of specific coping strategies, questions arise surrounding how to measure the experience of moral distress. Can moral distress be measured in an objective manner through the use of measurement tools? How can moral distress be measured if there are several widely used definitions of moral distress in the scholarly literature? The use of different terms for "moral distress" within the literature strongly suggests the need for a formal concept analysis on moral distress to reach an all encompassing or single definition of moral distress. A broader and more comprehensive definition and understanding of the concept of moral distress will provide the foundation upon which management strategies and measurement tools can be developed. These tools could assist to determine levels of moral distress experienced, which types of moral dilemmas most commonly lead to moral distress, and the evaluation of management strategies an individual, unit, and organization can implement to cope with and/or alleviate moral distress within the workplace.

In today's high operational tempo, additional research is fundamental for preventing occupational stress injuries (e.g., depression, post-traumatic stress disorder), maintaining deployable staff, and

retaining staff within the military. A more comprehensive understanding of the prevalence and occurrence of the contributing factors within the unique environment to moral distress from ongoing research will contribute to the development of further interventions to support deployed CF nurses and their team members providing health care in morally challenging situations.

Limitations of the Study

When interpreting the results of this study, there are limitations that should be considered. Firstly, the researcher is a CF military nurse who has been deployed twice, and is a senior officer in the CF. These factors may have had some effects on the findings as the researcher's own moral dilemmas, experienced during both deployments, may have influenced the analysis of the data. Administrative or disciplinary action concerns due to the investigator's senior rank in the CF may have influenced both recruitment and participants' full disclosure of their morally challenging situations. To reduce the possible influence of these variables, specific strategies were employed. Member checks, a review of the study's findings by a Mental Health expert responsible for the emotional needs of the soldiers and health care providers, and the involvement of the thesis committee in the review of the data collection and analysis process contributed to ensuring the validity of the findings.

An additional study limitation involved the method of data collection. Six of the ten interviews were completed over the phone and consequently the researcher was unable to visualize any of the participant's non-verbal cues during the interview process, and had to rely on changes in speech patterns and pitch to draw attention to key passages that were more easily noted in the face-to-face interviews. A third limitation of the study involves the open inclusion criteria, as there was no time limitation between when the CF nurses had been last deployed and their participation in this study. Although participants deployed several years ago appeared to experience the same process of moral deliberation and moral

impact as those more recently deployed, the extended period of time between their deployment and the interview may have influenced their ability to accurately recall their experiences and may have influenced their present interpretation of them.

Finally, caution must be taken when applying the results of this study to other military contexts, as the population studied here may not be representative of other deployed military nurses from other countries who may have been deployed in different circumstances, and with differences in their military forces' ethos, values, and beliefs.

Conclusion

The findings of this study revealed that moral distress was a prominent work area phenomenon affecting CF nurses deployed in combat or humanitarian missions. This understanding informed the development of a new Moral Distress Model, which reflects the military context of deployed CF nurses through its central category of "Unique Environment" and the continuous influence of this category on all phases of the model. The new model also reflects the development of moral distress through a two-phased process of moral deliberation and moral impact. The central category of the "Unique Environment" suggests that deployed CF nurses experience situations and moral dilemmas not commonly experienced by civilian nurses working in civilian facilities in Canada, which predisposes them to moral distress.

In summary, this study found that moral distress experienced by the CF deployed nurses who participated in this study was prominent and often led to negative effects on the respective nurse, the team, the chain-of-command, and the organization. Educational and supportive strategies suggested for the individual and the team combined with pre-deployment and ongoing training in coping with morally challenging medical situations may serve to mitigate the significant impact of moral distress experienced

by nurses, and contribute towards enhancing the deployed experience of CF nurses serving abroad for the Canadian Forces.

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Appendix A

Table A1

Effects of Moral Distress

Effect	Symptom	Nurses Affected (%) (n = 12)
Emotional	• Sadness	• 67
	• Anger	• 67
	• Frustration	• 42
	• Guilt	• 17
	• Fear	• 8
	• Disgust	• 8
	• Discouragement	• 8
Physical	• Pain:	
	• Headache	• 25
	• Neck	• 17
	• Muscle	• 17
	• Stomach	• 8
	• Sleeping dysfunctions:	
	• Dreams about work	• 8
	• Tired	• 8
• Insomnia	• 8	
Social	• Feelings/concerns verbalized to family/friends	• 58
	• Living will/wishes discussed with own family	• 25
	• Physical withdrawal from family/friends	• 17
Professional	• Reluctance to come to work/care for patient	• 50
	• Emotional/physical withdrawal from others	• 42
	• Introspection and reflection	
	• Questioned nurses' role and appropriateness of care	• 17
	• Questioned leaving [unit]	• 8
	• Question if nurses are providing high-quality care	• 17
	• Hesitant/refusal to primary patients	• 24
• Refusal to participate in work-related committees	• 8	
Other	• Sickest workers in Canada	
	• 50% of nurses have acted against their conscience	
	• 1 in 3 nurse have experienced moral distress	
	• Experience moderate levels of moral distress	
	• 15% left the discipline altogether	

Note. Table adapted from Gutierrez, 2005, p. 235; except for "Other", which was adapted from AACN, 2006a; CNA, 2003; Corley, 1995; Corley et al, 2001; Corley et al, 2005; Elpern, 2005.

Appendix B

Online Search Strategies for Moral Distress

Keywords*	Strategy	Actions	Results
<ul style="list-style-type: none"> • Moral distress • Nurs\$ • Nursing practice • Critical care nurses • Military nurses • Military medical personnel • Military • Morals • Ethics • Questionnaires • Scales • Surveys • Coping • Coping strategies • Strategies • Stress • Stress, occupational • Stress, psychological • Stress management 	<p>Databases (English only)</p> <p>CINAHL MEDLINE PsychINFO EMBASE Scirus Cochrane Review</p>	<ul style="list-style-type: none"> • Utilized a number of combined searches to decrease hits to search strategy • Combinations focussed on: 1) moral distress (+ all other keywords except morals and ethics); 2) morals, ethics, and stress + survey, scales, and questionnaires • Focus of search was on articles within 5 to 7 years and available electronically 	<ul style="list-style-type: none"> • Articles older than 1998 were seminal studies : Jameton (1984) and Wilkinson (1987/88). • Articles of interest were reviewed and chosen based on applicability to topic • Articles ranged from position statements from professional associations to various studies (See Appendix B)

* Applicable to database strategy only

Appendix C

Cover Letter Sent by Electronic Mail to Commanding Officers

CO,

This letter is being sent to inform you of a research project that will be taking place at a number of Canadian Forces' Medical Units. The project will be investigating moral dilemmas and the distress they may cause in Regular and Reserve Force Canadian Forces Nursing Officers (CF nurse) who have been deployed on an overseas mission.

When faced with a morally challenging situation, a CF nurse may experience moral distress when a decision they have made regarding what he/she believes to be the right course of action, but a number of factors prevent them from carrying out or completing the action. Research has linked moral distress to burnout, decreased quality of care, and staff shortages such as, sick time and leaving the discipline altogether. In military terms, this can negatively impact the number of available nurses to meet deployment needs while increasing the demands on those who remain.

It has been proposed the work environment deployed nurses work in may subject them to situations and other stressors not seen in civilian facilities or while in-garrison. This difference may expose the military nurse to more frequent and intense moral situations that could lead to moral distress. While numerous civilian studies exist that have researched nurses and moral distress, there is a lack of research on CF nurses and moral distress. Therefore, this project seeks to determine how moral distress affects deployed CF nurses and the process these nurses go through when faced with these situations (i.e., feelings, sources, experiences, and management strategies).

To achieve this end, your unit has been considered as a potential source to recruit participants for this research project. At a time convenient to you, I would like to discuss the intent, plan, and end-state of this project within your unit lines.

Please read the attached Information Letter and Consent Form from the researchers for more detailed information about the research project and what your personnel's participation would entail.

Ethics approval to conduct this study has been attained from both the University of Ottawa and the Canadian Forces. This study is part of my course requirements to complete my Masters in Nursing Program at the University of Ottawa.

For your consideration and approval, sir.

C.T. Bradshaw
Master's of Nursing Program
University of Ottawa

Appendix D

English Recruitment Poster



Canadian Forces Military Nursing Officers And Moral Distress

Are you a Regular or Reserve Force Nursing Officer?

Have you been deployed on an overseas mission?

**Would you like to share your stories and examples of moral dilemmas you
experienced while deployed?**

By means of a personal interview, the purpose of this study will be to explore your stories and examples and discuss the feelings, symptoms, sources, steps and management strategies Nursing Officers have felt and/or employed to address moral dilemmas and the distress they may have caused.

**If you would like to participate and/or to receive more information about
this study:**

**Please contact the Primary Investigator at
either**

This study is being conducted by Trevor Bradshaw, RN, BScN, Masters of Nursing Student, School of Nursing, University of Ottawa as part of his course requirements and under the supervision of Dr. Susan Brajtman, RN, PhD, Assistant Professor, School of Nursing, University of Ottawa and has received approval from the University of Ottawa and the Canadian Forces Ethics Review Boards.

Interviews will be conducted in English only and take about 30 – 60 minutes.
Information sheets and consent forms are available in French upon request.

Appendix E

French Recruitment Poster



LES OFFICIERS EN SOINS INFIRMIERS DES FORCES MILITAIRES CANADIENNE ET LA DÉTRESSE MORALE

Êtes vous un officier régulier ou réserviste en soins infirmier ?

Avez-vous déjà été déployé en mission outre-mer ?

**Voulez-vous partager vos histoires et vos exemples de détresses morales
vécues lors de vos déploiements?**

Par le biais d'une entrevue individuelle, le but de cette étude est d'explorer vos histoires et vos exemples et de discuter des sentiments, des symptômes ressenties, en plus des sources, des étapes et la gestions des stratégies utilisés par les Officiers en soins infirmiers pour faire face aux dilemmes moraux et à la détresse qu'ils ont pu causée.

**Si vous voulez participer ou recevoir plus d'information au sujet de cette
étude:**

Communiquez avec Trevor Bradshaw :

Cette étude est menée par Trevor Bradshaw, RN, BSCN, étudiant à la Maîtrise en soins infirmier, Université d'Ottawa, comme exigence pour son cours et sous la direction du Dr. Susan Brajtman, RN, PhD, Professeure Adjointe, École des Soins infirmiers, Université d'Ottawa et a reçu l'approbation des Conseils de revue d'éthique de l'Université d'Ottawa et des Forces Armées Canadiennes.

Les entrevues d'une durée de 30 à 60 minutes seront menées en anglais.
Les feuilles d'information ainsi que les formulaires de consentement sont disponibles en français sur demande.

Appendix F

Introductory Email for Recruitment

Dear Sir/Ma'am:

You are being sent this email to inform you of, and recruit you for, a research study to be conducted by a Masters of Nursing Student at the University of Ottawa as part of his course requirements. This study will be looking at moral dilemmas and the distress these dilemmas cause in Canadian Forces Nursing Officers, both Regular and Reserve Force, during an overseas deployment/mission.

If you feel that you would be interested in participating in this study, I invite you to review the two file attachments to this email that outline the study in further detail and provide the contact information for enrolment into the study.

Regardless of whether you wish to enrol or not, there are no expectations or requirements from the Canadian Forces to suggest and/or encourage participation in this study nor will there be any repercussions or actions taken against your career if you choose not to.

Yours truly,

Trevor Bradshaw
Primary Investigator
Masters in Nursing Program
University of Ottawa

Appendix G

English Information Letter for Participants**Study Information Letter for Participants**

Title of the study: Canadian Forces Military Nursing Officers And Moral Distress:
A Grounded Theory Approach

Researcher:

Trevor Bradshaw, RN, BScN, Masters of Nursing Student
School of Nursing, University of Ottawa

Thesis and Study Supervisor:

Dr. Susan Brajtman, RN, PhD, Assistant Professor
School of Nursing, University of Ottawa

Thesis Committee Members:

Dr. Betty Cragg, RN, PhD, Director and Associate Dean
School of Nursing, University of Ottawa

Dr. Kathryn Higuchi, RN, PhD, Assistant Professor
School of Nursing, University of Ottawa

This Patient Information Sheet is provided for you to describe the study you are invited to participate in. Please read it carefully and feel free to ask all questions you may have before deciding whether you wish to participate.

Purpose: You are invited to participate in a research study, conducted by a Masters of Nursing Student at the University of Ottawa, that will be looking at moral dilemmas and the distress they cause in Canadian Forces Nursing Officers (CF nurses), both Regular and Reserve Force, who have been deployed on an overseas mission.

During a deployment, factors such as the work environment (terrain, hospital structure, weather, team cohesion), chain-of-command, rules of engagement and operational mandates may create additional situations that challenge a CF nurse's morals and principles in the delivery of health care to their patients. The moral dilemmas these situations cause often lead to distress, termed moral distress, which occurs when a decision has been made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action. The purpose of this study is to describe the processes CF nurses go through by exploring the moral dilemmas they have faced and discuss the feelings, symptoms, sources, and management strategies they have felt and/or employed to address moral dilemmas and the distress they may have caused.

Procedure and Duration of Participation: You will be asked to complete a private face-to-face interview with the Primary Investigator (PI) at a time and location convenient to you. The interview will be tape-recorded and take approximately 30 – 60 minutes to complete. If you are unable to attend or wish to cancel the interview, it would be appreciated if you could contact the PI beforehand.

The interview is set up around three key premises: demographics (e.g., gender, years nursing, number of deployments, etc.), situations and effects of moral distress, and issues of attrition and management strategies. Clarifying and/or validating questions may be asked to ensure the PI accurately understands your stories.

Further participation may involve a follow-up phone call to discuss and review the general findings proposed by this study for feedback and validation from a randomly selected individuals who participated in this study. The phone call should take approximately 20 minutes to complete.

While the PI will be conducting all phases of the study, the additional researchers listed above consist of the PI's thesis supervisor and thesis committee and will have access to the raw data and will provide assistance in all phases of the study as required.

Confidentiality: For all participants, including those who have withdrawn from the study, your data will be identified by a designated code throughout the study to ensure confidentiality is protected and no personal identifying information will be revealed (e.g., demographic information, what unit the participant belongs to) when the study is published. Furthermore, the data will be locked up in a filing cabinet at the home/office of the PI for during the duration of the study and then transferred to a locked filing cabinet at the Canadian Forces Director General of Health Services indefinitely upon completion of the study. Access to the data will be restricted to the researcher, thesis supervisor and committee members listed on the first page. You will not be identified in publications or presentations.

If, at any time, you withdraw from the study, any and all of your data collected will be destroyed immediately upon notification of your withdrawal and will not be used in the study. If, in addition to withdrawing from the study, you wish to receive a copy of the data through the Access to Information Act, then you must state this at the same time you withdraw from the study and accept that failure to do so will void any future requests for a copy, as the data will have been destroyed. Moreover, if a participant withdraws and wishes to have a copy of their data, then the conservation of the data will be done in the same fashion as above until the PI has been informed that your request has been fulfilled, at which time, the data will be destroyed.

Risks: It is anticipated that your participation in this study will involve minimal risks, which include:

- Time commitment involved to complete the interview;
- Time commitment involved with follow-up phone calls concerning data findings;
- In order to protect your anonymity and confidentiality, no compensation will be given for the time committed to participating in this study or any costs incurred;
- The interview may cause you to discuss situations that may portray superiors or supervisors in a negative fashion and go into subject matter that is of a sensitive nature and may cause you to relive stressful situations and strong emotions;
- The purpose of the interview is to elicit your experiences with moral dilemmas. Contact information will be provided for professional intervention, if you require it at anytime during or after the interview, and;
- A Masters of Nursing student, who is also a senior Nursing Officer, will be conducting the interview. However, the study is being done as part of their course requirements and is sponsored by the University of Ottawa. Any experiences, situations, or conflicts discussed in this forum will remain confidential through the use of codes, consent to quote from an interview, and access to all raw data will be limited to those researcher, thesis supervisor and committee members listed above.

Benefits: A potential benefit is the opportunity to increase your awareness and knowledge concerning moral dilemmas and how it may have affected you during your deployment(s). It is through your stories that this study will attain its purpose and lead to a greater understanding of moral dilemmas, the distress it causes, and its influence on CF nurses. Another possible benefit is the outcomes of this study may illuminate and/or support the implementation of organizational management strategies.

Voluntary Participation: There are no expectations or requirements from the Canadian Forces to suggest and/or encourage your participation in this study. Therefore, you are under no obligation to participate in this study and may refuse to participate, refuse to answer any of the questions, cease the interview, and/or withdraw from the study at any time without any repercussions to your career. You understand that you will not give up any legal rights by enrolling in this study.

Compensation: No monetary or material compensation will be given to you as a study participant.

Ethics: If you have any questions with regards to the ethical conduct of this study, you are encouraged to contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5; tel,: (613) 562-5841 or by email: ethics@uottawa.ca and/or the Protocol Officer at Canadian Forces Medical Group Headquarters, 1745 Alta Vista Drive, Ottawa ON, K1A 0K6; tel,: (613) 996-0427.

If you are interested in participating in this study, please contact:

Trevor Bradshaw

Please keep this study information sheet for your records.

Appendix H

French Information Letter for Participants**Lettre d'information au sujet de l'étude à l'intention des participants**

Titre de l'étude: La détresse morale et les officiers en soins infirmiers des forces militaires canadiennes : une approche théorique sur le terrain.

Chercheur :

Trevor Bradshaw, RN BScN, Étudiant en Maîtrise en soins infirmiers
École des soins infirmiers, Université d'Ottawa

Directrice de mémoire et de l'étude :

Dr. Susan Brajtman, RN, PhD, Professeure Adjointe
École des soins infirmiers, Université d'Ottawa

Membres du comité de mémoire :

Dr. Betty Cragg, RN, PhD, Directrice et Doyenne Adjointe
École des soins infirmiers, Université d'Ottawa

Dr. Kathryn Higuchi, RN, PhD, Professeure Adjointe
École des soins infirmiers, Université d'Ottawa

Cette feuille d'information pour bénéficiaire vous est remise afin de vous décrire l'étude à laquelle vous êtes invité à participer. Avant de prendre la décision de participer, prière de lire cette feuille attentivement et n'hésitez pas à nous adresser toutes vos questions.

Objectif: Vous êtes invité à participer à cette recherche, dirigée par un étudiant à la Maîtrise en soins infirmiers de l'Université d'Ottawa qui portera sur les dilemmes morales et la détresse qu'ils provoquent chez les Officiers en soins infirmiers des forces militaires canadiennes qui servent présentement dans la Force Régulière ou celle de la Réserve et qui ont été déployés en mission outre-mer.

La Théorie sur le terrain est une approche de recherche qualitative qui recherche les interactions entre les individus, la société et le phénomène. Son but est de découvrir des liens et des théories qui seront ensuite appliqués à l'ensemble des Officiers en soins infirmiers des forces militaires canadiennes.

La détresse morale survient lorsque, lors d'une situation donnée, une décision, qui se veut selon l'individu la meilleure à ce moment, est prise mais des obstacles empêchent l'infirmier (ère) d'agir et de répondre à la situation. L'objectif de cette étude est d'explorer la détresse morale chez les officiers en soins infirmiers des forces militaires canadienne et de développer un modèle sur la théorie et la détresse morale. Ceci sera accompli à travers cet objectif spécifique : décrire le processus (e.g. les sentiments, sources, symptômes, expériences et stratégies) de la détresse morale chez les officiers en soins infirmiers de Forces Militaires Canadiennes qui ont été déployés outre-mer.

Procédure et durée de la participation: Votre engagement dans cette étude consistera à participer à une entrevue face-à-face et à fournir de la rétroaction à propos des résultats de l'étude par un suivi via un ou deux appels téléphoniques. Si vous choisissez de participer, l'enquêteur principal (EP) vous contactera afin de fixer un rendez-vous selon votre disponibilité. Avec votre accord, l'entrevue sera enregistrée et durera environ 30 à 60 minutes selon vos réponses. Si vous ne pouvez assister à l'entrevue ou désirez l'annuler prière de contacter le EP à l'avance.

L'entrevue consistera d'une série de questions qui recherchera les informations les plus pertinentes par rapport à vos expériences de détresse morale et celles-ci seront utilisées au besoin. Cependant, nous vous encourageons à guider l'entrevue plutôt que d'utiliser une méthode d'entrevue formelle. Nous vous demanderons des questions additionnelles afin de faciliter la conversation ou pour clarifier vos propos.

Le EP conduira toutes les phases de l'étude alors que les chercheurs additionnels précités, qui sont les directeurs de mémoire ainsi que les membres du comité de mémoire du EP auront accès aux données brut et procureront de l'aide, au besoin, lors de toutes les étapes de l'étude.

Confidentialité: Afin de protéger l'identité des participants, incluant les candidats qui se sont retirés de l'étude, toutes leurs données seront identifiées et encodées tout au long de l'étude et aucune information pouvant identifier l'individu ne sera révélée (e.g. démographie, son unité informations utilisées dans les citations si l'étude est publiée). Ces données seront entreposées, pour la durée de l'étude, dans un cabinet fermé à clef à la résidence ou au bureau de l'enquêteur principal. Lorsque l'étude sera complétée elles seront ensuite transférées et gardées indéfiniment dans une filière fermée à clé chez le Directeur Général des Services De Santé des Forces Armées Canadiennes. L'accès à l'information sera limité à l'enquêteur principal, aux assistants en recherche, au directeur de mémoire et au comité de mémoire. Vous ne serez identifié dans aucune publications ou présentations.

Si, à n'importe quel temps, vous vous retirez de l'étude toutes les informations que vous nous avez fournies seront détruites immédiatement lorsque nous recevrons la confirmation de votre retrait et celles-ci ne seront pas utilisées à l'intérieur de l'étude. Si, en plus de vous retirer de l'étude, vous désirez

recevoir une copie des données selon la Loi sur l'Accès à l'Information, vous devez l'indiquer en même temps que votre retrait de l'étude et accepter que le non-respect de cette demande annulera toute demande ultérieure car les données auront été détruites. De plus, si un participant se retire et désire une copie de leurs données; la préservation de ces données sera effectuée selon le protocole précédemment citée jusqu'au moment où le EP sera informé que votre demande a été exécutée. A ce moment, les données seront détruites.

Risques: Nous anticipons que votre participation à cette étude comporte un minimum de risques, qui peuvent être:

- Votre engagement en temps afin de compléter l'entrevue;
- Votre engagement en temps pour les suivis téléphoniques reliés aux résultats;
- Afin de protéger l'anonymat et la confidentialité, aucune rémunération ne sera accordée pour le temps dévoué à l'étude ou autres coûts associés;
- L'entrevue vous demandera de discuter des sujets qui pourraient vous faire revivre des situations stressantes et faire surgir des fortes émotions telles(mais non limitées à) la colère, l'anxiété, le regret et la peine;
- L'entrevue peut vous amener à discuter des situations qui pourraient dépeindre vos supérieurs ou directeurs de façon négative;
- Le but de l'entrevue est de découvrir vos expériences de détresse morale. Elle ne sert pas de session de counselling et ne procure aucune intervention. Cependant, nous offrons un service d'intervention professionnel sur place, durant et après l'entrevue, si vous le désirez et en ressentez le besoin, et;
- Un étudiant à la Maîtrise en soins infirmiers, étant également un Officier supérieur en soins infirmiers, dirigera l'entrevue. Cependant, l'étude fait partie des exigences de son cours qui est commanditée par l'Université d'Ottawa. Toutes expériences, situations ou conflits discutés lors de ce forum demeureront confidentiels par l'usage de codes, consentements pour l'utilisation des citations provenant des entrevues, et l'accès aux données brut sera limité aux chercheurs, au directeur de mémoire et aux membres du comité.

Bénéfices: L'entrevue pourrait vous offrir l'opportunité d'accroître votre sensibilisation et vos connaissances sur la détresse morale et comment celle-ci peut vous avoir affectée lors de votre ou vos déploiements. A travers vos récits cette étude va atteindre son objectif et permettre une meilleure compréhension de ce qu'est la détresse morale et son influence sur les officiers en soins infirmiers des Forces Armées canadiennes. Un autre gain serait que les résultats de cette l'étude pourraient engendrer des études plus approfondies, un développement d'une échelle d'évaluation et l'implantation de stratégies pour augmenter la rétention, améliorer le milieu de travail et diminuer l'épuisement professionnel et les congés de maladie.

Participation volontaire: Il n'y a aucune attente ou exigence de la part des Forces Armées Canadiennes qui suggère et/ou encourage votre participation à cette étude. Vous n'avez aucune obligation de participer à cette étude et vous pouvez vous retirer en tout temps. Votre refus de participer, refus de répondre à certaines questions ou cesser l'entrevue n'auront aucune répercussion sur votre carrière. Vous comprenez qu'en signant ce document qu'aucun droits légaux ne vous sont enlevés.

Indemnité: Aucune indemnité monétaire ou matérielle ne vous sera versée en tant que participant à cette étude.

Éthique: Si vous avez des questions d'ordre éthique par rapport à la conduite de cette étude, vous êtes invité à vous adresser à l'Officier du protocole pour l'éthique en recherche, Université d'Ottawa, Salon Tabaret, 550 rue Cumberland, Salle 159, Ottawa, ON K1N 6N5 : tél :613-562-5841 ou par courriel ethics@uottawa.ca et/ou Officier du protocole au quartier général du groupe médical des Forces armées canadiennes, 1745 Promenade Alta Vista, Ottawa, ON K1A 0K6, tél : 613-996-0427.

Si vous êtes intéressé à participer à cette étude, communiquez:

Trevor Bradshaw

SVP gardez cette feuille d'information sur l'étude pour vos dossiers.

Appendix I

English Consent Form for Participants**Consent Form for Participants**

Title of the Study: Canadian Forces Military Nursing Officers and Moral Distress:
A Grounded Theory Approach

Researcher:

Trevor Bradshaw, RN, BScN, Masters of Nursing Student
Primary Investigator (PI)
School of Nursing, University of Ottawa

Thesis and Study Supervisor:

Dr. Susan Brajtman, RN, PhD, Assistant Professor
School of Nursing, University of Ottawa

Thesis Committee Members:

Dr. Betty Cragg, RN, PhD, Director and Associate Dean
School of Nursing, University of Ottawa
Tel: (613) 562-5800 Ext. 5426

Dr. Kathryn Higuchi, RN, PhD, Assistant Professor
School of Nursing, University of Ottawa

Purpose of the Study: The purpose of this study is to describe the processes that Canadian Forces Nursing Officers (CF nurses) go through by exploring the moral dilemmas they have experienced and the distress they may have felt during any of their overseas deployment(s). This purpose will be accomplished by means of a face-to-face interview, with both Regular and Reserve Force CF nurses, that seeks to reveal the feelings, symptoms, sources, and management strategies they may have felt and/or employed to address moral dilemmas and the distress these dilemmas may have caused.

Procedure: My participation in this study will consist of a face-to-face interview with the Primary Investigator (PI) at a time convenient to myself. With my approval, the interview will be tape-recorded and should take approximately 30 – 60 minutes to complete dependent upon my responses. If I am unable to attend or wish to cancel the interview, I will contact the PI within 24-hours of my appointment to rebook or withdraw from the study. Further participation may involve a follow-up phone call to discuss and review the general findings proposed by this study for feedback and validation from a randomly selected individuals who participated in this study. The phone call should take approximately 20 minutes to complete.

I understand that the interview is to be conducted in a participant guided and open manner to gain the most from my experiences with moral dilemmas but predetermined questions may be posed to me to encourage discussion. I recognize that additional questions may be asked to help clarify and/or verify what I have said.

The study, consisting of the interview and/or general educational session will be conducted in English only.

While the PI will be conducting all phases of the study, the additional researchers listed above consist of the PI's thesis supervisor and thesis committee, will have access to the raw data, and will provide assistance in all phases of the study as required.

Risks: I understand that participation in this study will require me to discuss subject matter that is of a sensitive nature and may cause me to discuss superiors or supervisors in a negative fashion and/or relive stressful situations that may lead to strong emotions such as (but not limited to) anger, anxiety, regret, and sadness. As a result, I have been made aware that arrangements for professional intervention will be in place, if I require them at anytime during or after the interview.

I am aware that a Masters of Nursing student, who is also a senior Nursing Officer, will be conducting the interview. However, I understand that the study is being done as part of their course requirements and is sponsored by the University of Ottawa. Any conflicts, experiences, or situations discussed in this forum will remain confidential through the use of designated codes, my written consent to quote from my interview, and that access to all raw data will be limited to the researcher, thesis supervisor and committee members listed above only.

I understand and accept that there will be no compensation for my time or costs incurred from participating in this study in order to protect my anonymity and confidentiality.

Benefits: My participation in this study will provide me with the opportunity to increase my awareness and knowledge concerning moral dilemmas and how it may have affected me during my deployment(s).

In addition, my participation will lead to a greater understanding of moral dilemmas, the distress it causes, and its influence on CF nurses at an organizational level, which may lead to further study and the implementation of strategies to mitigate the distress moral dilemmas may cause during an overseas deployment.

Confidentiality and Anonymity: In order to ensure my anonymity, I am aware that the interviews will be conducted after work hours or during holidays, in a non-military or medical setting agreeable to myself, in civilian dress, and that I do not have to gain permission to enrol or participate in the project from my chain-of-command. In addition, the use of codes for the participant, base, and tour location will be employed throughout the study, including any quotations used in publication of the findings.

I have received assurance from the PI that the information I will share during this study will remain strictly confidential, even if I withdraw from the study. I understand that any information I provide through the interview and any follow-up will be anonymous and that only codes will be used to identify my information. I have been instructed that only the researcher, thesis supervisor and committee members listed above will see the raw data, which will be locked up in a filing cabinet at the Canadian Forces Director General of Health Services indefinitely upon completion of the study. I have been made aware that the findings will be published but no personal identifying information will appear in any presentations, quotations, or published reports.

Conservation of Data: The data collected, interview notes and tapes, and electronic data such as compact discs with information pertaining to the study, will be locked up in a filing cabinet at the home/office of the PI for the duration of the study and then transferred to a locked filing cabinet located at the Canadian Forces Director General of Health Services indefinitely upon completion of the study. Access to the data will be restricted to the researcher, thesis supervisor and committee members listed on the first page. I will not be identified in publications or presentations. If I withdraw from the study at anytime, I am aware that any data collected will be destroyed immediately upon notification of my withdrawal and will not be used in the study. If, in addition to withdrawing from the study, I wish to receive a copy of my data through the Access to Information Act, then I must state this at the same time I withdraw from the study and accept that failure to do so will void any future requests for a copy as the data will have been destroyed. I understand that if I withdraw *and* want a copy of my data, then the conservation of my data will be done in the same fashion as above until I inform the PI that my request has been fulfilled, at which time, the data will be destroyed.

Voluntary Participation: I understand that there are no expectations or requirements from the Canadian Forces to suggest and/or encourage my participation in this study. I recognize that I am under no obligation to participate in this study and as such, I may refuse to participate, refuse to answer any of the questions, cease the interview, and/or withdraw from the study at any time without any repercussions to my career.

Acceptance: I _____, agree to participate in a research study conducted by Trevor Bradshaw and under the supervision of: Dr. Susan Brajtman, Dr. Betty Cragg, and Dr. Kathryn Higuchi of the University of Ottawa. I understand that by agreeing to participate I am in no way waiving my right to withdraw from the study.

Moreover, I am aware that under the Access to Information Act, Canadian citizens are entitled to obtain copies of research reports and research data (including the database pertaining to this project) held in Federal government files. Similarly, under the Privacy Act, Canadian citizens are entitled to copies of all information concerning them that is held in Federal government files including research databases. Prior to releasing requested information, the Directorate of Access to Information and Privacy (DAIP) screens the data to ensure that individual identities are not disclosed.

In addition to providing consent to participate:

I do / do not wish to possibly be contacted for a follow-up phone call to discuss the overall findings of the study.

I do / do not give permission to take quotes from my interview for the use in presentations and/or publications.

If I feel the need for additional emotional support, as a result of this interview, I am to contact the:

CF Members Assistance Program

I am aware that if I have any further questions I can contact the Primary Investigator, Trevor Bradshaw, If I have any questions regarding the ethical conduct of this study I may contact the Protocol Officer for Ethics in Research, University of Ottawa, at (613) 562-5841 or ethics@uottawa.ca and/or the Protocol Officer at Canadian Forces Medical Group Headquarters

Two copies of the consent form exist, one is mine to keep and the PI will retain the other.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Appendix J



French Consent Form

Formulaire de consentement pour participants

Titre de l'étude : Les officiers en soins infirmier des Forces Militaires Canadiennes et la détresse morale

Chercheur :

Trevor Bradshaw, RN BScN, Etudiant en Maîtrise en soins infirmiers
École des soins infirmiers, Université d'Ottawa

Directrice de mémoire et de l'étude :

Dr. Susan Brajtman, RN, PhD, Professeure Adjointe
École des soins infirmiers, Université d'Ottawa

Membres du comité de mémoire :

Dr. Betty Cragg, RN, PhD, Directrice et Doyenne Adjointe
École des soins infirmiers, Université d'Ottawa

Dr. Kathryn Higuchi, RN, PhD, Professeure Adjointe
École des soins infirmiers, université d'Ottawa

Objectif de l'étude: L'Objectif de cette étude est d'explorer la détresse morale chez les officiers en soins infirmiers des Forces militaires canadiennes et de développer un modèle sur la théorie et la détresse morale. Ceci sera accompli à travers cet objectif spécifique : décrire le processus e.g. les sentiments, sources, symptômes, expérience et stratégies) de la détresse morale chez les officiers en soins infirmiers des Forces Armées Canadiennes qui ont été déployés dans des missions outre-mer.

Procédure: Ma participation à cette étude consistera en une entrevue face-à-face avec l'Enquêteur principal (EP) selon ma disponibilité. Avec mon accord, l'entrevue sera enregistrée et durera environ 30 à 60 minutes selon mes réponses. Si je ne peux assister à l'entrevue ou désire la annuler, je communiquerai avec le EP dans les 24 heures qui précède mon rendez-vous pour réserver un autre temps ou pour me retirer de l'étude.

Une participation ultérieure pourrait comprendre un suivi téléphonique d'une durée approximative de 20 minutes auprès d'un nombre aléatoire de participants afin de discuter et de revoir les résultats provenant de l'étude pour fin de rétroaction et de validation.

Je comprends que l'entrevue sera conduite de manière ouverte et guidée par le participant de façon à rechercher les informations les plus pertinentes par rapport mes expériences de détresse morale et que des questions prédéterminées me seront posées afin d'encourager la discussion. Je reconnais que des questions additionnelles peuvent être ajoutées afin de faciliter la conversation ou pour clarifier mes propos.

L'étude qui comporte entrevue et/ou une session d'éducation générale se déroulera en anglais seulement.

Le EP conduira toutes les phases de l'étude alors que les chercheurs additionnels précités, qui sont le directeur de mémoire ainsi que les membres du comité de mémoire du EP auront accès aux données brut et procureront de l'aide, au besoin, lors de toutes les étapes de l'étude.

Risques: Je comprends que participer à cette étude créera une situation dans laquelle je discuterai de sujets qui pourraient me faire revivre des situations stressantes et faire surgir des fortes émotions telles (mais non limitées à) la colère, l'anxiété, le regret, et la peine. A cause de ceci, je suis au courant qu'un service d'intervention professionnel sera disponible sur place, durant et après l'entrevue, si je désire et j'en ressens le besoin.

Je suis conscient q'un étudiant à la Maîtrise en soins infirmiers, étant également un Officier supérieur en soins infirmiers, dirigera l'entrevue. Je comprends que l'étude fait partie des exigences de son cours qui est commanditée par l'Université d'Ottawa. Toutes expériences, situations ou conflits discutés lors de ce forum demeureront confidentiels par l'usage de codes, par mon consentement écrit pour l'utilisation des citations provenant de mon entrevue, et l'accès aux données brut sera limité aux chercheurs, au directeur de mémoire et aux membres du comité.

Afin de protéger mon anonymat et ma confidentialité, je comprend et accepte qu'aucune rémunération pour mon temps ou autres coûts associés ne me seront accordés.

Bénéfices: Ma participation dans cette étude me fournira l'occasion d'augmenter ma conscience et connaissance à propos de dilemmes moraux et comme il m'a pu affecter pendant mon déploiement. De

plus, ma participation mènera à une plus grande compréhension de dilemmes moraux, la détresse qu'il cause, et son influence sur CFNOs à un niveau d'organisation qui peut mener pour étudier plus loin et la mise en oeuvre de stratégies atténuer la détresse les dilemmes moraux peuvent causer pendant un deployment(s) d'outre-mer.

Confidentialité et anonymat: Afin d'assurer mon anonymat, je suis conscient que les entrevues auront lieu après mes heures de travail, pendant mes vacances ou lors de journées fériées dans un endroit de mon choix à l'extérieur du milieu militaires ou médical. Je serai en tenue civile et n'aurai besoin de la permission de mes supérieur pour participer au projet. De plus, j'ai été informé que le participant, sa base et son lieu de déploiement seront identifiés par codes tout au long de l'étude, incluant toutes citations utilisées dans les publications.

J'ai reçu l'assurance du EP que l'information que je partagerai pendant cette étude demeurera confidentielle, même si je me retire de l'étude. Je comprend que l'information que je donnerai lors de l'entrevue et des conversations téléphoniques seront anonymes et que des codes seront utilisés afin d'identifier mon information. Je fus informé que seulement les chercheurs, le directeur de mémoire et les membres du comité précité auront accès aux données brut. Une fois l'étude terminée, celles-ci seront gardées indéfiniment dans une filière fermée à clé chez le Directeur Général des Services de Santé des Forces Armées Canadiennes. On m'a expliqué que les données seront publiées mais qu'aucune information pouvant m'identifier ne paraîtra dans les présentations, les citations ou les rapports publiés.

Conservations des données: Ces données recueillies seront entreposées, pour la durée de l'étude, dans un cabinet fermé à clef à la résidence ou au bureau de l'enquêteur principal. Lorsque l'étude sera complétée elles seront ensuite transférées et gardées indéfiniment dans une filière fermée à clé chez le Directeur Général des Services De Santé des Forces Armées Canadiennes. Après ce temps, tous les documents, enregistrements et électroniques seront détruits. L'accès à l'information sera limité à l'enquêteur principal, aux assistants en recherche, au directeur de mémoire et au comité de mémoire.

Je ne serai identifié dans aucune publications ou présentations. Si je me retire de l'étude toutes les informations que j'ai fournies seront détruites immédiatement lorsque vous recevrez la confirmation de mon retrait et celles-ci ne seront pas utilisées à l'intérieur de l'étude. Si, en plus de me retirez de l'étude, je désire recevoir une copie des données selon la Loi sur l'Accès à l'Information, je dois l'indiquer en même temps que mon retrait de l'étude et j'accepte que le non-respect de cette demande annulera toute demande ultérieure car les données auront été détruites. De plus, si je me retire et désire une copie de mes données. La préservation de ces données sera effectuée selon le protocole précédemment citée jusqu'au moment où le EP sera informé que ma demande a été exécutée. A ce moment, les données seront détruites.

Participation volontaire: Il n'y a aucune attente ou exigence de la part des Forces Armées Canadiennes qui me suggère et/ou m'encourage de participer à cette étude. Je n'ai aucune obligation de participer à cette étude et je peux me retirer en tout temps. Mon refus de participer, refus de répondre à certaines questions ou cesser l'entrevue n'auront aucune répercussion sur ma carrière.

Consentement: Je, _____, accepte de participer à une étude de recherche conduite par Trevor Bradshaw, Dr. Betty Cragg, Dr. Susan Brajtman et Dr. Kathryn

Higuchi de l'Université d'Ottawa. Je comprend qu'en acceptant de participer je ne renonce pas à mon droit de me retirer de l'étude.

De plus je comprend que selon la Loi sur l'Accès à l'information, tous citoyens canadiens ont le droit d'obtenir des copies des rapports de recherche et des données de recherche (incluant la base de données reliée à cette étude) conservées dans les filières du gouvernement. De même, sous la Loi de la protection des renseignements personnels, les citoyens canadiens ont le droit de recevoir des copies sur toutes les informations qui les concernent et qui sont conservées dans les filières du gouvernement fédéral, incluant les bases de données pour les recherches. Avant de divulguer l'information demandée, le Directeur à l'Accès à l'Information et à la Protection des renseignements personnels filtre les données afin d'assurer que l'identité des individus n'est pas dévoilée.

En plus de fournir un consentement pour participation :

J'accepte/n'accepte pas d'être contacté lors d'un suivi téléphonique pour discuter des résultats de l'étude.

J'accepte/n'accepte pas de donner ma permission d'utiliser des citations provenant de mon entrevue pour fin de présentations et / ou publications.

Suite à cette entrevue, si je ressens le besoin de plus de soutien émotionnel, je dois faire appel à : _____ au _____. (Les coordonnées de la personne ressource ne seront fournies que lorsque l'Université d'Ottawa et les Forces Armées Canadiennes auront données leur accord du point de vue éthique).

Je suis au courant qu'en cas de questions supplémentaires je peux communiquer avec le EP, Trevor Bradshaw, _____ Si j'ai des questions d'ordre éthique par rapport à la conduite de cette étude je peux communiquer avec l'Officier du protocole pour l'éthique en recherche _____ ou ethics@uottawa.ca et / ou Officier du protocole au quartier général du groupe médical des Forces Armées Canadiennes

Deux copies du formulaire de consentement existent, une pour moi-même et la seconde sera retenue par le EP.

Signature du participant: _____ Date : _____

Signature du chercheur: _____ Date: _____

Appendix K

Semi-structured Interview Format

1. Before we start the interview, I would like to reconfirm that you still do not have any objections to the taping of this interview and the taking of notes? If the individual objects to being taped and/or the taking of notes, the participant will be informed that the investigator will be writing an overview of our interview immediately after its completion.

2. Before we begin talking about your experiences, I would like to get some demographic information from you:
 - a. What is your age?
 - b. What is your marital status?
 - c. Do you have any children?
 - d. Are you in the Regular Force or Reserve Force?
 - e. How many years have you been nursing?
 - f. How many years have you been nursing in the military?
 - g. How soon after achieving your nursing licence were you deployed?
 - h. How many times have you been deployed?
 - i. Under what auspices were you deployed? (*UN / NATO / DART / Other*)
 - j. What position did you hold while you were deployed?
 - k. What type of structure did you live and work under? (*Canvas/hard structure*)
 - l. What was the danger level of your mission? (*If known*)

3. Have you faced any morally challenging situations while on deployment? Can you tell me about which one was the most significant to you?
 - a. Under which tour did this situation occur? (*UN, NATO, DART, Other*)
 - b. With this situation, can you describe what happened?
 - c. Was your response to the situation, based on what you wanted to do? Please explain. Influencing factors?
 - d. How did your response to the situation make you feel?
 - e. With this situation, was there something you did that helped you deal with the feelings you felt? Please explain. **Give examples if required.** (*e.g., diaries, talk with colleagues*)
 - f. With this situation, what has stayed with you the most? (if not revealed)

If time allows, return to #3 for the other situations they have experienced.

- g. If applicable, can you tell me how these experiences may have influenced how you feel about: *(Do one at a time)*:
- i. Yourself (as a person *and* as a nurse);
 - ii. The healthcare team you were deployed with;
 - iii. The unit (if applicable);
 - iv. Nursing, and;
 - v. Being in the military.
4. If you wanted the military to know about anything from your experiences, what would you want them to know? *(F/U w a probe about helpful suggestions if required)*
5. Is there anything that you would like to add?
6. Before we end the interview, I would like to take this time to remind you that support is available if you feel the need to talk to someone:
- a. Ottawa:
 - i. 1-800-268-7708 (CFMAP)
 - ii. 613-945-6600 (ask for Unit DO/MO)
 - b. Petawawa:
 - i. 1-800-268-7708 (CFMAP)
 - ii. Pager #613-635-0011 (Unit Duty MO)
 - iii. Unit Padre: Lt(N) Jean Johns 613-687-5511 x6485
 - iv. Mental Health/Soc W Dept 613-687-5511 x6141
7. THANK YOU!

Appendix L

Grounded Theory Definitions

Term	Definition/Use
Open Coding ¹	<ul style="list-style-type: none"> • “The analytic process through which concepts are identified and their properties and dimensions are discovered in data” (p.101)
Axial Coding ¹ / Theoretical Coding ²	<ul style="list-style-type: none"> • “The process of relating categories to their subcategories, termed “axial” because coding occurs around the axis of a category, linking categories [to subcategories] at the level of properties and dimensions” (p. 123) • Reassembles data fractured during open coding • Utilizes 6 C’s of theoretical codes: <ul style="list-style-type: none"> • Cause – reason, source, or explanation of phenomenon occurrence(s) • Consequences – result, outcome, or effects of phenomenon • Covariance – used to explain nature and extent of the relationship between variables • Contingencies – describe the direction of the variance • Context – captures social world of individuals engaging in the phenomenon under study • Conditions – examined to capture range and variance under which the phenomenon occurs (pp. 41-42)
Selective Coding ¹	<ul style="list-style-type: none"> • “The process of integrating and refining the theory” (p. 143).
Central Category ¹	<ul style="list-style-type: none"> • Represents the main theme of the research • Should appear frequently in the data and is central (i.e., all other major categories can be related to it)
Memo Writing ^{1,2}	<ul style="list-style-type: none"> • Written records of the analytical process by the author and for the author • Serves to let researcher know where they were, are, and need to go • Should be dated, titled, cross-referenced, and filed
Diagram Drawing ^{1,2}	<ul style="list-style-type: none"> • Visual representation of the categories and how they link together • Illustrates the researcher’s analytical scheme • Assists in identifying gaps and providing an overview of data

Note. Table developed by investigator and adapted from the definitions by Strauss & Corbin¹ (1998) and Chenitz & Swanson² (1986).

Appendix M

Questions and the Story Line

Question: Under causes of moral distress, what strategies are used to mitigate or stop moral distress?

Answer: The data revealed that regardless of the cause, the process by which a CF nurse dealt with a moral dilemma went through two equally important steps: 1) making a moral action choice (to act or not to act) and 2) dealing with the repercussions (moral distress) if a) the choice to act is blocked, stopped or overruled or b) inaction was chosen.

Step 1 reveals that the properties seen in the causes have both a broad and narrow aspect. The former is seen in all causes, while the latter is situational specific. For example, in all causes of moral distress, there is a decision to make from the known options. This involves a decision process consisting of issues such as: responsibility, conflict, difficulty, impasse, and desirability of choices. In addition to this process, other broad properties included: situational frequency, commonness, and number of situations (causing distress) plus one's job, level of connection to the issue, length of deployment, time, one's values, stakeholders involved, and that no cause or situation is clear cut and easy (multidimensional).

Given the two sets of properties for each cause, it became apparent that all causes of moral distress had a similar two-tiered level of response or strategy to deal with the situation. This two-tiered level of response and/or strategies used started with strategies employed in all causes (ALL). These strategies were broader in nature and dealt with aspects of: acceptance, reflection, coping, fighting for one's action choice, release, mentoring, and most importantly feeling right about their action/inaction(s) and being able to sleep at night. There were those specific strategies employed to deal with the specific cause respectively (See Excel file – Axial Coding Report). However, the data revealed that often regardless of the cause, similar strategies were employed.

This two-tiered (broad/narrow) theme continued with the intervening conditions. Common to all were the effects of the following conditions on the strategies: attachment and accountability (to situation), career and life goals, collegial influences (comradery, support, personal and work relationships), culture (mil and civ), daily challenges, expectations, experience, operational influences (tempo, danger), organizational factors (disconnection with reality, recognition, mgmt), personal characteristics and value/belief system, physicians, power, team cohesion, and willingness to act. It was apparent that these common conditions played a huge role on the decisional process in addition to the intervening conditions specific to a given cause of moral distress.

Question: What can be said when looking at the common properties, strategies, and intervening conditions?

Answer: The data illustrated that there is a common process in dealing with a cause that leads to moral distress. While specific factors exist concerning a given cause, their role seemed somewhat lesser in its influence on the process than the role of the common factors. The reason for this is that often the specific strategic factors considered were put to the test by the common strategic factors, influencing conditions, and properties. This can be seen in the following questions revealed from the literature (in order of importance): What can I live with? What will allow me to sleep at night? How will this affect my career, my tour and post tour relationships, and me? Will my choice change me? Is it (my moral action choice) worth it?

What this reveals is that the decisional process of deciding on a moral action choice takes as much energy and cost to the individual as moral distress does when the choice is blocked. Here the idea of stakeholders plays a larger part than I originally thought. For example, higher levels of moral distress were seen when: an individual was very passionate/close to a situation; the action choice impacted

another beyond themselves (especially in cases where *inaction* was the choice); patients were involved and the action choice was not “how we normally do it back in Canada”; and fighting the “man” (physicians, the organization).

Question: As a result of the causes, are there different levels of moral distress?

Answer: Yes. As explained above, the type of situation and whom it involves (personal, team, organization) creates different levels of moral distress. In addition, an individual’s sensitivity or susceptibility to moral distress is not solely related to their sense of responsibility but is also tied to unresolved moral distress and (surprisingly) non-moral distress causing stressors (daily challenges) such as: sleep, amenities, food, space, tempo, living quarters, and socialization, and the unique environment. As many of the causes of moral distress mainly went unresolved for lengthy periods of time, the impact of the daily stressors and the unresolved moral distress, was revealed to lead to such a level as seen in crisis states illustrated in stress models. It was at this point that many of the participants felt that unless action occurred, the repercussions would be so great that they would lose themselves, do something unthinkable, and/or negatively impact their quality of patient care.

Other aspects affect the level of moral distress are surrounding the aspects of controllable and uncontrollable decision influencers whether they are external or internal factors, as a result of one’s tour expectations and perceived factors, and/or based on lingering issues (as per above). What this means is that controllable factors, unrealistic expectations and inaccurate perceptions, and any lingering issue led to higher levels of moral distress when a choice is blocked than if the opposite was seen.

Overall, it reveals a process/mini framework that needs to start with a moral dilemma → decision process that includes: the unique environment of a deployment and all other influencers (external, internal, perceived, lingering and residual issues) → moral action choice → blocked → moral distress

and/or outrage → moral impact (repercussions) on individual, team, organization, and discipline → moral residue (pos and neg) → influence on future moral action choice(s) for similar and/or different moral dilemma(s).

Question: This decision process seems important. Why so?

Answer: It is important because how an individual comes to a decision is related to the energy expended in deciding on a course of action. Because when a moral action choice is made, the data revealed that all participants were surprised when their choice was blocked. Many responses talked about the CF's underlying ethos and values or what defines an officer in the CF. Often the decisions made by the individual reflected these beliefs and when the outcome doesn't fit into this Rockwellian picture or the other stakeholders disagree, scoff, ignore or trivialize the situation, then the resulting moral impact (pers, team, org) and residual effects were very high (especially for the remainder of the tour¹)! Moreover, their decisions and the outcomes led to considerable repercussions such as (but not all inclusive): changing their core values and beliefs, leaving nursing, leaving the military and losing their sense of self.

In addition, the decision process, while containing a number of commonalities in the properties, strategies and conditions, is also influenced significantly by specific P, S, & Cs. This dual impact of common and specific factors supports the importance of the decision process to moral choice as the consequences of blocked choice are much more common regardless of the cause when compared to the decision process. In other words, the data revealed that for a specific cause only a few specific consequences were seen (mainly for pt care del) but a much larger number of common consequences (approx 49) were seen regardless of the cause.

¹ In the case of future tours, a coming to terms seemed to occur where most stood by their decision and would do the same again when dealing with pt care. However, for organizational issues (chain-of-command, professionalism, and moral trg), the decision to do the same was on shaky ground (often tempered by "The Core" or that part of self that could not be sold out)

Specific consequences:

- a) Pt care del: abuse, depersonalization of care, quality of care, withdrawal
- b) Chain-of-command: feeling threatened, view of leadership, (loss of) respect
- c) Moral prep/trg: poorly prepared, increased susceptibility/sensitivity
- d) Professionalism: incompatibility btwn colleagues/disciplines, constant judgement, (lack of) respect, loss of effective communication, poor team cohesion

In addition to the above, the decisional process to *ACT* is based on: who is affected and what one can sleep with. Action occurred the quickest when surrounding aspects of the pt and pt care del but was often delayed when the issues involved others (when action will affect someone else negatively; superiors) and most delayed when it dealt with one personally (did not want to hurt others). With the exception of pt care issues, action often occurred when self-protection, self-preservation, and saving oneself was all they had left (end-of-their rope). While only one participant stated that how they respond to deployment situations are how they would normally respond, most felt that the major driving for to ACTION was: what decision can I live with? What decision will let me sleep at night?

As I look at this, moral distress cannot be seen as unto its own. The decision process has to be there too. So do we call it moral distress? I'm not so sure now. Can we coin the term MORAL DELIBERATION? This is similar to Nathaniel's moral reckoning but I like moral deliberation because it reveals two things: to determine something (such as a decision) and determination represents a sense of willpower, resolve, and purpose. Moreover, this also illustrates that an action takes place, which ALWAYS leads to an outcome! This can easily fit in with the effects of a blocked decision and MORAL IMPACT! Where the "impact" represents the influence and the "forcefulness" of the effects.

Question: So why are all the above questions important?

Answer: The easy answer is that no study has been done on this population. However, the answer the data revealed lies in the level of moral preparation/training, shifting mind set, differing influencing factors, environment (work and living), forced confinement to the camp, an inability to find release, frequency and intensity of the events, and the physician or nurse dynamic.

Moral preparation and training:

- a) A common theme to each scenario was the sense of “What do I do?” Even dilemmas that appeared to have a simple solution were rife with conflicting value and decision choices. For example, the CF nurses that dealt with the colleague in contravention of regulations, it would appear to be a “slam-dunk”. They talked to the individual as friends and the individual should have respected that and stopped the behaviour. But when they didn’t, the others didn’t know what to do next as they were heavily conflicted with the only available option left – reporting this person. Not so simple when the chain-of-command doesn’t help AND the individual having relations was their roommate! The outcomes from the data illustrated that often the participants faced so many different factors surrounding the available options that it was overwhelming in deciding what to do. This was most often linked by the participants to a lack of moral preparation during pre-deployment trg.

Shifting Mind set

- a) Another aspect that came through in the area of pt care del, dealt with the idea of having to shift one’s mindset in how, to who, and for how long one gave pt care del. What is interesting to note, is this shift of mindset dealt only with civilian pts whether they are an ally, enemy, or

non-combatant. Throughout everyone's trg, they have learned a system of triage and care del based on the MOI and an individual's priority level. In Canada, the del of care is relatively unlimited and is really only influenced by whether a patient dies or not and/or by their own/family's wishes. During a deployment, this does not change for coalition and Cdn soldiers, as backwards movement and/or repatriation occur based on prognosis/MOI. However, for the civilian pt, the shift in mindset appears to be based on: care delivered and how the civilian pt is viewed.

b) Care delivered: the physical shift of how care is delivered required all participants to shift their mindset as the goal of returning a pt to the best level of recovery does not fully exist in the deployment setting. During a deployment, the data revealed that the idea of triage (based on priority injuries/conditions) was further applied to the idea of who got tx, (beyond stabilization) what level of tx they received, and for how long they get treated before transferring and/or letting them go occurred (TRIAGE CARE). This illustrates a shift in the bioethical influences on care del where the highest emphasis is placed on DISTRIBUTIVE JUSTICE regardless of the situation, where triage care del is determined by: avail resources, staffing, supply, space, duration of facility stay, regulations, mandates, security, and/or the availability of D/C care (family, civilian facility capabilities). This shift can be summed up as: *What we could do versus what we can do.*

i. Repercussions: the idea of control influenced each participant differently. Most recognized that the shift to a distributive way of determining care was outside of their control and did the best they could with what they could do given the circumstances involved. The largest issue was due to prolonging tx/suffering and logistics (space/resources). The data revealed that in these circumstances many

nurses employed DEPLOYMENT ADVOCACY, where a nurse either advocated for the pt being cared for or they advocated for those who are awaiting care when the prognosis (not necessarily priority) was more favourable.

c. View of the civ pt: this was the hardest mind shift for all participants who talked about pt care del. Most described caring for enemy soldiers, as the most difficult thing to do. It led to a depersonalized view of the pt and an onslaught of negative emotions not felt before – disgust, hatred, contempt, and indifference (to whether the civilian pt lived or died) – in their del of nursing care. In other words, care was purely physical and mandated versus holistic. This view was more apparent/evident when it was known/perceived that the pt killed Canadian soldiers and/or the pt was abusive (physically and verbally). As for non-combatants and FF civs, the issue of familial sp and discharge care led to the aspect of deployment advocacy above and the depersonalization of care as a self-protective strategy. *An interesting note here is the perception of CF nurses that the physicians were experimenting and/or going WAY beyond what was required in the del of care. While unsubstantiated by physicians, it raises the issue of perceptions and a potential dichotomized view of the pt (nurses see whole pt and influencing factors; docs see someone to save regardless of influencing factors). Do doctors only want to save? And if so, why? To sleep at night, to do some good, to save themselves? Would nurses be okay if they had to make the decision (versus advising the decision) to let someone die?*

In the end, bullet c) illustrates clearly how most were not aware that they would face these issues during a deployment → “What do I do?”

Influencing factors:

- a) The data revealed that regardless of the cause of moral distress, the influencing factors on answering the question “what do I do?” surrounded four main categories: external influencers, internal influencers, lingering issues, and perceptions (See table). Listed for each influencer (in the table) are those key bullets/subcats, which the data revealed to play a larger factor in arriving at a moral action choice = MORAL DETERMINATION. One of the key players here deals with the reality of war and the environment whereby the CF nurses work and live. These four main categories also capture all parts of this question’s answer.
- b) A point to consider about lingering issues and/or the feedback aspect of moral distress illustrated that the impact from past experiences did not come up very often in the data. The reason for this finding lay in the fact that 70% of the participants had completed only one deployment. However, what is key to note is that most felt that the outcomes of their experiences would affect their future decisions, especially in similar causes/situations of moral distress. That being said, changing from action to inaction was not a given. The choice to not act would only occur if they did not sacrifice their core principles or lose themselves as a result of inaction but when action did occur, it would most likely be delayed because of their negative experiences with the chain-of-command or health care team.
- c) The notion of the expectations and perceptions each individual brings to the moral determination process revealed that they often favoured the moral action choice of inaction. The data revealed there was the underlying feeling that being a good soldier means staying silent and that speaking out shows disloyalty, taking action will negatively impact one’s career, and will not be supported by the chain-of-command, the chain-of-command is self-serving/self-protective

entity and that nurses are powerless or overruled when choosing action and a superior/physician is involved. How's that for standing up for one's moral choice?

Environment

- a) The deployed nurse, regardless of humanitarian or combat mission, is held "captive" at their camp for all aspects of life – work, socialization, and rest. What this means is that for the duration of the tour (outside of vacation time) you eat, sleep, live, and breathe each other at work, rest, and play. Therefore, the aspect of team cohesion, both work and social related, becomes a necessary part of surviving a tour intact. If relationships become fractured, you cannot get away from the other person, camps become divided, and sp may flag.
- b) During a deployment, many of the amenities, to which we are used to, do not exist or are limited. Logistical issues such as access to showers, bathrooms, recreation and living arrangements are not always geared to be comfortable and promote a sense of well-being. Canvas is not as nice as hard structure!
- c) Deployment environment leads to a heightened and prolonged sense of stress – exposure to diseases; potentialities of the camp being attacked, being shot, or being threatened or attacked by a patient; the inability to remove oneself from the environment; OP tempo; and always being on call (no real downtime). Remember this is most often over a period of 6 months!
- d) Loss of normal sp structures! The data revealed that participants protected their normal sp structures from much of what they experienced and/or they were unable to access them. Sp had to be found with their deployed colleagues – problematic if an issue arises or one cannot find a sp structure! In one case, this led to an awful deployment, which saw a significant withdrawal from the team and the chain-of-command and ultimately led to leaving their trade and in another case will most likely lead to leaving the military altogether.

e) Deployment length was also a player in the process. Aspects of staff turnover (usually physicians) saw a return of moral distressing situations already addressed with their predecessors R/T their seniority and differing views of how things should be done. Chain-of-command often saw it as an issue of “Can we not just get along? The deployment is only for x number of months, can’t you just suck it up?” The deployment length is also linked to the timing of the moral situation. As the end of a tour got closer, individuals were more reluctant to address a situation. The length of TI also saw a lowered level of tolerance to moral situations.

Finding release:

a) This is heavily tied to sp structures and the camp environment. Many talked about being unable to find a way to release negative issues. Strategies employed included reading, talking with colleagues, and journaling. These were effective up to a point. Reading allowed pers to relax but did not necessarily help one deal with the issues at hand. Journaling was found to be effective both during and after deployment as it was a way of getting things out and reminding one of what they came from. Collegial sp was a mixed response. Some said it was an integral part to surviving a deployment while others felt that as time progresses; the discussions actually became more destructive than helpful in finding release. This accumulation often led to an extreme response – see Interview 1 AY (cutting off life sp), 6 FZ (fearing for their lives), 7 GY (leaving military?), and 10 JY (left trade).

b) Tied with finding release is the issue of chain-of-command support. In all cases, chain-of-command support or input was sought early and in some cases, frequently to address the moral situation the individual and/or group faced. More than naught, the chain-of-command at the higher levels was unsupportive and/or did little to mitigate the situation and/or uphold the values,

beliefs, and regulations of the CF. It should be noted that first level management was most helpful but often was rendered powerless to act.

Frequency and Intensity:

a) In looking at the causes of moral distress and their respective dimensions, the overall findings speak volumes concerning the aspect of frequency and intensity of situations that lead to moral distress:

- a. Intensity – high
- b. Duration – continuous
- c. Location – everywhere and anywhere
- d. Trajectory – for the entire tour
- e. Obtained help – generally early on but it was a continuous process

Physician or nurse Dynamic:

The physician or nurse dynamic consisted of issues surrounding: hierarchy, professionalism, and dichotomized view of how care should be delivered.

The conflict between the two disciplines was revealed to occur as a result that CF nurses were often overruled based on the subordinate role versus their input; not having their (CF nurses) input being heard or sought out despite being with the patients 24/7 or being too junior or inexperienced; a lack of professional respect from physicians; a dichotomized view of the civilian patient (nurse save who we can; doctors save everybody regardless); or as a result of physicians being in power at higher levels of the chain-of-command who may be protecting their own. For example, 10 JY, the CO's (a physician) response was "it's his nature...you're not going to change him"

One of the issues revealed in the data deals with time not being available for a piece-meal team to go beyond just clinical trg and actually getting to know each other before deploying. This is especially true due to the higher numbers of augmentees seen in recent deployments. As a result, the CF nurses felt required to prove themselves clinically and as worthy participants for the provision of input on how health care is delivered.

While only one participant brought this up, it would be interesting to see if their feelings that gender plays a role on how this dynamic interacts is true. Unfortunately, the aspect of gender did not come up again as it pertained to this dynamic.

Question: So what about the consequences?

Answer: Unlike the P, S, & C's, there was fewer specific consequences to the causes of moral distress. More than naught, all causes led to the same type of consequences (See Excel file). But what is key to note from the consequences is that the impact of action/inaction is beyond the stakeholders involved. Rumours, innuendos, changes in how we see each other, fractured relationships, perceptions of inaction/officers protecting officers occur as a result of the decision(s) made, which serve to erode the working relationships btwn supervisors, colleagues and subordinates alike. It's like a bomb footprint.

As a result of this footprint, the consequences are seen as MORAL IMPACT and affects four groups: the individual, the team, the chain-of-command, and the organization (See model). All groups vividly reflect the cost of moral distress and its moral impact. The end result is that future impact on a future decision will be influenced by whether the individual feels that action is futile, not worth the cost, they will be acting alone (no C-of-C sp), and that the organization really doesn't care. So why bother?

Appendix N

Table N-A *Moral Impact (All Levels)*

Consequences (Negative)	<ul style="list-style-type: none"> • Verbal and physical violence/abuse to hospital staff (particularly nurses and medical technicians) • Significant cost with moral action choice: <ul style="list-style-type: none"> • Emotional, psychological, and physical energy • To one's self and how they now define themselves • To one's working and social relationships (fractured? cohesive?) • Cost to self is dependent on the moral dilemma faced: <ul style="list-style-type: none"> • Clinical (lowest) • Personal • Others/Relationships (highest) • Fear (of acting, of Consequences, of other's perceptions of them) • Job satisfaction • Loss of faith in: <ul style="list-style-type: none"> • Chain-of-command • Each other • The system • Leads one to choose inaction or silence especially when the chain-of-command fails to support and act on behalf of those in need • Marginalization of subordinates • Loss of self or the negative redefinition of self when compared to pre-deployment self • Desire to leave specialty or the military • Left one's specialty • Increased and lingering stress levels • Self-blame (even if they are the victim or the situation is beyond their control)
Consequences (Negative)	<ul style="list-style-type: none"> • Lack of sleep • Self doubt (personal, clinical) • Segregation and withdrawal

<p>Consequences (Negative)</p>	<ul style="list-style-type: none"> • Damaged value and belief system • Poor reflection on trade, branch, or officers (especially when chain-of-command is perceived to be inactive) • Intensity of negative emotions is high and its influence on the individual is linked to their satisfaction with their moral action choice (most often seen as a result of reflection) • Increased effect of moral distress when support structures cannot be accessed both normal (family) and deployment whether by choice (protect family) or due to fractured deployment relationships
<p>Consequences (Positive)</p>	<ul style="list-style-type: none"> • Job satisfaction • Increased sense of pride in self, discipline, branch, and country • Able to live with one's self • Able to sleep • Stronger sense of comradery and team cohesion • Call for pre-deployment training in moral dilemmas specifically aimed towards medical personnel

Table N-B

Future Impact on Moral Distress Process

<p>Future Impact (Negative)</p>	<ul style="list-style-type: none"> • Increased sensitivity to insignificant complaints and petty ignorance given the living conditions of the local population • Increased distress when a (civilian) patient responds negatively to the care provided • The lack of chain-of-command support in moral issues and adherence to regulations when convenient has led to negative views of the medical branch • Ongoing frustration with: <ul style="list-style-type: none"> • Poor moral training and preparation • Poor MCSP opportunities • Current skills set • OP tempo and resources
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<p>Future Impact (Negative)</p>	<ul style="list-style-type: none"> • Chain-of-command • No change occurs to immoral behaviour committed by others • Decreased decisional involvement • Doing the “right thing” doesn’t always feel good • Second-guessing moral action choice (“What if I had acted?” “Was what I did, the right thing to do?”) • Accumulation of moral distress related to inability to vent or get release and inability to access a non-judgemental support system • Outcomes/prognosis different (“We could’ve saved his life, if we were in Canada” “Once we discharge him, he will die”) • Having to continually “do the right thing” on behalf of others • Lack of professional respect
<p>Future Impact (Positive)</p>	<ul style="list-style-type: none"> • Personal growth from experience(s) (e.g., increased resolve)

Appendix O

Table O-A

External Influencers

Category	External Influencer
Environmental (Civilian)	<ul style="list-style-type: none"> • Priority to care in military facility when allied mass casualty occurs • Priority to care in military facility based on OP mandate • Current state of country's medical infrastructure: • Quality, accessibility and availability of civilian facilities for patients • Quality and accessibility of discharge care for civilian patients
Environmental (Military)	<ul style="list-style-type: none"> • Number of beds in military facility • Availability, amount in-stock, and resupply of expendable resources • Availability of technical support services (e.g., lab, Xray, OR) • Camp logistics: <ul style="list-style-type: none"> • Security • R&Q • Bathrooms/showers • Welfare • Communication (phone, internet, postal) • Time to respond/deal with situation • When during the tour did the situation occur • Frequency of the situation (multiple times, continuous) • Number and priority of casualties during a mass casualty • Location of military medical facility • OP tempo and its effects on time and resources • Danger and threat level • Organizational effects • Admitting/Holding timelines (e.g., ICU: transfer after 48 hours)

Category	External Influencer
Personal (Civilian)	<ul style="list-style-type: none"> • Type of civilian patient (friendly or enemy) • Gender, prognosis and age of civilian patient • Willingness of patient to be treated in military facility • Response to treatment (belligerent, violent, abusive, thankful) • Injured patient fighting against coalition (potentially injured Canadian soldiers) • Familial support at military facility and/or for discharge care • Locals' support towards and perception of the military medical facility located in their area
Personal (Military)	<ul style="list-style-type: none"> • Career goals (to be a nurse, to be promoted) • Accurate civilian cultural knowledge and acceptance • Affects of daily stressors (daily challenges) • Amount of decision power • Amount of exposure to moral distressing situation • Closeness and sense of responsibility to the moral distressing situation • Positive working and social relationships • Having to access a new support structure • Need to protect normal support structures from deployment events • Inability to access normal support structures • How long has the individual been in theatre? • Ability to vent and/or release emotions through appropriate management or coping strategies (e.g., journaling, open discussions) • What message is sent with the decision made?
Personal (Team)	<ul style="list-style-type: none"> • Interprofessional respect • Level of patriarchal/hierarchical nature of the team • How we normally respond clinically to a situation in Canada versus how we respond in a deployment (personal and team conflict) • Compatibility of core values and beliefs of the individual with supervisors, colleagues, and subordinates • Stakeholders in a situation and their respective decision power and responsibility • Staff turnover (mostly involves specialists)

Category	External Influencer
Personal (Team)	<ul style="list-style-type: none"> • Openness of communication within the team dynamic (supportive and understanding of each other, involvement in the treatment plan/decision) • Mortality rates (especially with Cdn and/or allied soldiers) • Level of experience and skills currency that each team member has
Personal (Organization)	<ul style="list-style-type: none"> • OP security • Preparation and training • Is the organization: <ul style="list-style-type: none"> • Connected • Listening to their subordinates (specific circumstances, after-action reports) • Supportive and protective • Seen to be upholding regulations for all personnel • Willing to take action both disciplinary and administrative

Table O-B

Internal Influencers

Category	Internal Influencer
Personal	<ul style="list-style-type: none"> • Desire to represent country/to go on tour (despite skill preparation) • Level of commitment and conviction to military ethos and being an officer • What are the individual's core values and beliefs? How do they define themselves • Level of commitment and conviction to core personal values and beliefs • Level of experience (novice, intermediate, expert) and career goals • Expectations of one's self, colleagues, team, and organization • Expectations and perceptions of the current deployment • Fortitude • Often put others ahead of themselves

Category	Internal Influencer
Situational	<ul style="list-style-type: none"> • What energy cost is involved in action choice? Does it delay action? • What is the ‘most right’ decision that the individual can live with? • Level of connection/closeness to the issue (before and after) • Sense of responsibility to the stakeholders affected by the decision choice • Does the type of patient influence the individual’s perception of them (e.g., Cdn soldier is family; civilian patient is dispensable) • What cost is it to the individual when a choice must be made to save a Cdn soldier’s life but to do so means discharging a civilian patient who most likely will die due to the poor civilian medical infrastructure? • Limited resources lead to a depersonalization of health care delivery (e.g., blood supply) • What influence does the deployment have on job satisfaction
Perceptions	<ul style="list-style-type: none"> • A good soldier is one who remains silent. A soldier who speaks out is a disloyal soldier. • If an individual speaks out, their career will be negatively affected. • Even though one’s skills aren’t current, their career will be ruined if they express a need for more MCSP and/or refuse to deploy because of their skills. • The more medals one has, the better soldier they will be and the more respect they will have. • One is powerless to act in this situation • Even if one follows the regulations, they are a bad soldier who is disloyal and disruptive to the branch and have betrayed their colleagues, if they report someone who is acting immorally. • Even though one has the capabilities of participating and advising in the decision process, they have little say in the final decision. • One does not want to hurt anyone or anyone’s career because of their decision. • The expectations of the chain-of-command/colleagues/team of me are... • One is not a worthy participant in the treatment plan process because they are a junior/novice nurse. • Specialty nurses (e.g., ICU) are expert nurses with the most knowledge/skills. • Female nurses are better patient advocates. • Action does more harm than good, even if it hurts the individual more by staying silent. • One must be a good soldier who never complains and is always positive.

Perceptions	<ul style="list-style-type: none">• Based on one's (our) moral action choice, how is (are) one (we) viewed by others because of the situation (both before and after)?• Based on one's moral choice, the benefits of standing for what's right outweigh the risks or vice-versa.• The level of knowledge civilian patients has concerning medical treatments.• The outcomes will be the same in the future (if one chooses to act again).• If one was in Canada...• What the deployment and its demands will be like.• Nursing Officers are not seen as competent and useful professionals until judged as being so by the physicians and medical technicians.• Is it worth the effort to uphold regulations, mandates, and patient rights when I am or they are only here for ____ more months?• How will one's moral action decision define his or herself to: themselves; their colleagues; patients; organization?• The chain-of-command is a self-preserving and threatening entity.• The chain-of-command will always support moral action when regulations and personal rights are being violated.• The chain-of-command only hears what it wants to hear.
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