

Critical Care Nurses' Experiences of Coping with Moral Distress

Dana Forozeiya

A thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
in partial fulfillment of the requirements for the
Master's degree in Nursing

School of Nursing
Faculty of Health Sciences
University of Ottawa

Abstract

Over the last three decades, there has been a growing body of literature that has described moral distress as a prominent issue that negatively affects critical care nurses. However, little focus has been given to how nurses cope and continue on in their practice despite the hardship that moral distress can cause. This study sought to reveal nurses' strategies of coping with moral distress to allow for a better understanding of this aspect of critical care nurses' experiences.

This study adopted a qualitative design that used Thorne's (2008) approach to interpretative description. Face-to-face, semi-structured interviews were conducted with seven critical care nurses employed within two ICUs of a tertiary care academic hospital. Interviews were analyzed using Aronson's (1995) approach to thematic analysis.

The experience of coping with moral distress had an overarching theme of being "*like grass in the wind*." Four major themes were identified: *Going Against What I Think is Best*, *Moral Distress- It's Just Inherent in Our Job*, *It Just Felt Awful*, and *Dealing with It*.

Acknowledgements

First and foremost, I would like to thank my thesis supervisors Drs. Brandi Vanderspank-Wright and Frances Fothergill-Bourbonnais. Words cannot express just how grateful I am to have you as my supervisors. You have been beyond supportive since the first day that I started this thesis. You have helped guide me throughout this entire process. You encouraged me and believed in me at times when I needed it most. It has been an absolute pleasure working with you both! I would like to acknowledge my thesis committee members Drs. David Wright and Denise Moreau. David, you have been a mentor since the beginning of my Master's program. Thank you for sharing your expertise on moral distress. Your insight really helped challenge me to look at the concept in a different light. Denise, I want to thank you for all of the constructive feedback you provided. Your input has helped strengthen and shape this thesis.

I would like to acknowledge and thank the Ottawa Hospital Nursing Research Group for funding this study through granting the "Nursing Catalyst Award" and "Nursing Endowment Fund". I would also like to thank the Ottawa Hospital Nursing Research Group reviewers who took the time to offer feedback during the planning phase of this study.

To the seven nurses who shared their experience in this thesis, I extend genuine gratitude. I admire the strength and courage you had to share your stories and it was an honour to listen to them. I sincerely hope that I did your stories justice.

To my parents, you have always encouraged and supported me to reach my full potential. To my husband Jose who has listened to me summarize so much literature that he has become an expert on moral distress. I really could not have done it without you.

Baraye BaBa Bozorg, Dele BaBa, Dele BaBa.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Chapter 1: Introduction.....	1
1.1 Background	2
1.2 Problem Statement	4
1.3 Research Purpose	4
1.4 Research Objective.....	5
Chapter 2: Review of Literature	6
2.1 The Intensive Care Unit	6
2.2 Critical Care Nursing	8
2.3 Death in the Intensive Care Unit	10
2.4 The Concept of Moral Distress	12
2.4.1 Definition of moral distress.	12
2.4.2 Antecedents of moral distress.	16
2.4.3 Effects of moral distress.....	18
2.5 Sources of Moral Distress for Critical Care Nurses.....	20
2.6 Coping with Moral Distress	22
2.6.1 Strategies from professional nursing organizations.....	22
2.6.2 Coping in critical care.	23
2.6.3 Coping outside of critical care.	26
2.7 Summary of the Literature	28
Chapter 3: Methods.....	30
3.1 Research Design.....	30
3.2 Methodological Assumptions.....	32
3.3 Theoretical Scaffolding Process.....	33
3.4 Setting.....	35
3.5 Sample.....	36
3.5.1 Eligibility criteria.	36
3.5.2 Recruitment.....	37

3.5.3	Participant characteristics.....	38
3.6	Data Collection.....	39
3.7	Data Analysis.....	39
3.8	Methods to Ensure Rigor/Trustworthiness.....	41
3.8.1	Credibility.....	41
3.8.2	Confirmability.....	41
3.8.3	Transferability.....	42
3.8.4	Dependability.....	42
3.9	Ethics and Human Participant Protection.....	43
Chapter 4:	Findings.....	44
4.1	Overview of the Themes.....	44
4.1.1	The overarching theme: Like grass in the wind.....	46
4.2	Theme 1: “Going Against What I Think is Best”.....	46
4.2.1	Not doing the right thing.....	47
4.2.2	I knew what I needed to do.....	49
4.3	Theme 2: “Moral Distress- It’s Just Inherent in Our Job”.....	50
4.3.1	Working with uncertainty.....	51
4.3.2	Dealing with miscommunication.....	53
4.3.3	Resonance.....	56
4.3.4	Questioning the decisions of others.....	58
4.3.4.1	Decisions of patients’ families.....	59
4.3.4.2	Decisions of physicians.....	63
4.3.5	Prolonging care.....	65
4.4	Theme 3: “It Just Felt Awful”.....	68
4.4.1	Emotional characteristics.....	68
4.4.2	Physical characteristics.....	71
4.4.3	Psychosocial characteristics.....	72
4.5	Theme 4: “Dealing with It”.....	73
4.5.1	Having an outlet.....	75
4.5.2	Avoiding it.....	76
4.5.3	Connecting with someone who gets it.....	79

4.5.3.1	Trusting others.	79
4.5.3.2	Mentorship.	81
4.5.3.3	Having a safe haven.	83
4.5.4	Getting yourself back up.	84
4.6	Summary of the Findings	87
4.7	The Follow-up Interview.	88
Chapter 5: Discussion and Implications for Practice, Education and Research		89
5.1	Introduction	89
5.2	The Meaning of Moral Distress	89
5.2.1	Descriptions of moral distress.	89
5.2.2	Perceptions of the right action: Where do they stem from?.....	91
5.3	The Influence of Hierarchical Power	92
5.4	Moral Distress: Is it Recognized?	94
5.5	Remaining Morally Engaged within Practice	97
5.5.1	The importance of connecting with others.	98
5.5.2	The influence of nursing experience on coping.	99
5.5.3	The ability to get yourself back up.	101
5.6	The Participants' Coping Strategies: Relating Practice to Theory.....	103
5.7	Resilience	105
5.8	Implications for Nursing Practice, Education, and Research.....	106
5.8.1	Nursing practice.	106
5.8.2	Education.	110
5.8.3	Research.	112
5.9	Implications for Advanced Nursing Practice	112
5.9.1	Clinical.	113
5.9.2	Research.	114
5.9.3	Leadership.	115
5.9.4	Consultation and collaboration.	116
5.10	Limitations	116
5.11	Conclusion.....	118
References.....		120

Appendix A: English Recruitment Flyer	135
Appendix B: French Recruitment Flyer.....	136
Appendix C: English Recruitment E-mail Script	137
Appendix D: French Recruitment E-mail Script	138
Appendix E: English Information/Consent Form.....	139
Appendix H: French Information/Consent Form.....	144
Appendix G: English Interview Script.....	149
Appendix H: French Interview Script.....	150

Chapter 1: Introduction

Mr. L was a 45 year old male who had a cardiac arrest and fell unconscious at home. By the time the paramedics arrived, 15 minutes had passed where Mr. L was non-responsive and had not received any cardiopulmonary resuscitation (CPR). Paramedics had to intubate him, initiate and continue CPR for 10 minutes, and defibrillate him four times before there was return of spontaneous circulation. He was subsequently transported to the intensive care unit (ICU).

Two weeks after his cardiac arrest, he continued to reside in the ICU in a comatose, non-responsive state. He was dependent on life-sustaining therapies such as the ventilator and intravenous vasopressors. The CT and MRI scans of his brain revealed that he had a severe anoxic brain injury. The ICU physician explained to his wife that Mr. L had a poor prognosis and would remain in a persistent vegetative state. The physician recommended to her that the best course of treatment would be to withdraw all life-sustaining therapies so that Mr. L could have a comfortable, peaceful death. Though Mr. and Mrs. L had never discussed their wishes regarding end-of-life, Mrs. L resisted this treatment plan and stated that her husband would have wanted all therapies to have been continued because he was a 'fighter' who could overcome anything. Her wishes were respected and Mr. L's life-sustaining therapies were not withdrawn.

Sam, the critical care nurse caring for Mr. L, felt that she had to respect Mrs. L's decision but perceived that Mr. L was suffering and that his death was being prolonged. She viewed his quality of life as poor, which caused her to feel angry, sad and frustrated. Unsure of where to turn to for support, Sam began to contemplate whether she should leave her position within the ICU.

As a critical care nurse working in a Coronary Care Unit, encountering scenarios like the one presented above have been relatively commonplace within my practice. This scenario

represents just one of the many situations that my nurse colleagues and I have faced where we question whether what we are doing is right or wrong. When the perceived answer is the latter, I have both witnessed and experienced the impact that moral distress has on individuals. Due to the frequency that moral distress occurred for nurses in my practice, I developed a particular interest in the concept. Upon reviewing the literature, I found that there was a vast amount of research completed since the 1980's that has explored the concept of moral distress within nursing practice. However, little is known about nurses' experiences of coping with moral distress, so I sought to explore this phenomenon further.

1.1 Background

Moral distress has been articulated as a significant, frequently ignored problem within nursing practice (American Association of Critical-Care Nurses [AACN], 2008). The experience arises from a “perceived violation of one’s core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action” (Epstein & Hamric, 2009, p. 2). Moral distress is problematic for nurses as it is associated with negative emotions such as anger, sadness, frustration, and guilt. It may influence them to leave their nursing positions and, in some circumstances, to leave the profession entirely (Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Nathaniel, 2006; Piers et al., 2012; Sundin-Huard & Fahy, 1999; Wiegand & Funk, 2012; Wilkinson, 1988; Wilson, Goettemoeller, Bevan, & Mccord, 2013). Moral distress has also been noted to cause nurses to avoid patients and/or their families (Austin, Bergum, & Goldberg, 2003; Gutierrez, 2005), emotionally withdraw from them, minimize interactions with them (Gutierrez, 2005), and have a decreased level of patience with them (McClendon & Buckner, 2007). Consequently, patients can be less satisfied with the nursing care that they receive (Wiegand & Funk, 2012). The AACN

(2008) recognizes that moral distress significantly affects nurses' relationships with patients, as well as the quality and quantity of nursing care provided.

Moral distress commonly affects critical care nurses employed within ICUs (Browning, 2013). ICUs function to help critically ill patients survive by intervening with life-sustaining therapies (McClendon & Buckner, 2007). These therapies encompass all medical interventions that can sustain a patient's life such as dialysis, CPR, and mechanical ventilation (Johnstone, 2004). Due to the suddenness and severity of their illnesses, discussions with patients admitted to the ICU about their wishes regarding death and dying might not always occur or be possible in the context of critical illness (St Ledger et al., 2013). Patients can be left incapacitated or no longer competent to make their own decisions, and therefore their wishes and preferences regarding goals of care may be unknown. Instead, patients' substitute-decision makers must elicit their own personal beliefs concerning their interpretations of patients' preferences for decisions of whether life-sustaining treatments are withheld, withdrawn or continued (Wallen & Baker, 2012). Substitute-decision makers are the next-of-kin of patients and when patients are incompetent or incapacitated, clinical decisions are made on their behalf by substitute-decision makers (Heyland et al., 2003). When critical care nurses care for patients with life-limiting illnesses who are thought not to be improving despite the use of life-sustaining therapies, they may perceive these therapies as causing undue suffering and prolonging the dying process (Browning, 2013). Furthermore, when nurses enact or continue these therapies despite being inconsistent with their beliefs about what is morally correct, they can experience moral distress (Choe, Kang, & Park, 2015; Cronqvist, Theorell, Burns, & Lützén, 2004; Elpern et al., 2005; Ganz et al., 2013; Hamric & Blackhall, 2007; King & Thomas, 2013; McClendon & Buckner,

2007; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Oberle & Hughes, 2001; Sundin-Huard & Fahy, 1999).

The terms ‘critical care’ and ‘intensive care’ are often used synonymously within the nursing literature. Critical care is a broad umbrella term that encompasses all areas in which high intensity care is provided and can include acute settings such as recovery rooms and emergency departments (Williams et al., 2009). For the purposes of this thesis, the terms ‘critical care’ and ‘intensive care’ are used interchangeably.

1.2 Problem Statement

When nurses experience moral distress, it is not well delineated within the nursing literature how they cope with it. Coping refers to the cognitive and behavioural efforts made by individuals to manage internal and/or external demands which are perceived as being challenging or exceeding one’s resources (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). There is an abundance of literature that has focused on nurses’ experiences with moral distress to explicate its sources and characteristics (Austin et al., 2003; Calvin, Lindy, & Clingon, 2009; Choe et al., 2015; Elpern et al., 2005; Mobley et al., 2007; Piers et al., 2012; Shorideh, Ashktorab, & Yaghmaei, 2012; Wiegand & Funk, 2012; Zuzelo, 2007). However, to date, there is scant literature that has examined ways to cope with it. As such, this study was designed to explore and reveal nurses’ strategies of coping with moral distress to allow for a better understanding of this aspect of critical care nurses’ experiences.

1.3 Research Purpose

The purpose of this study was to explore critical care nurses’ experiences of coping with moral distress. The research question of interest was: “How do critical care nurses describe the experience of coping with moral distress?”

1.4 Research Objective

The objective of this study was to describe critical care nurses' experiences of coping with moral distress.

Chapter 2: Review of Literature

This chapter presents a review of the nursing literature on the context of the ICU and critical care nursing, the sources and characteristics of moral distress, and nurses' coping strategies. The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and PubMed databases were utilized to search for primary research articles related to the phenomenon of interest. Limits were applied to yield English, peer-reviewed articles and adult populations (18 years of age and older). Articles with neonatal and pediatric populations under the age of 18 were excluded. The rationale for this exclusion was the experience of moral distress was often associated with feelings of grief for nurses who worked within neonatal and pediatric ICUs (Davies et al., 1996; Lee & Dupree, 2008). As such, it was difficult to distinguish the concept of moral distress from grief. No limitations were placed on dates to ensure that a comprehensive literature review was achieved. Search terms for the sample/setting of interest included nurses, nursing, critical care, ICU, and intensive care. Search terms for the phenomenon of interest included moral distress, coping, and experiences. Published books and position statements were also used to broaden the researcher's understanding of moral distress and coping.

2.1 The Intensive Care Unit

ICUs are specialized units within hospitals that are equipped with advanced technology to provide highly specialized care to critically ill patients (Canadian Critical Care Society [CCCS], 2014). Their purpose is to help critically ill patients, most often at the brink of death, survive through the use of biomedical interventions (Hamric & Blackhall, 2007; St Ledger et al., 2013). Patients admitted to ICUs have severe, complex, life-threatening illnesses and/or injuries. Common admission diagnoses include trauma, sepsis, cardiac arrest, pulmonary, cardiovascular,

gastrointestinal, central nervous system and metabolic disease (Cook et al., 2003). To meet the needs of this patient population, ICU clinicians intervene with life-sustaining therapies such as artificial organs, intra-aortic balloon pumps, dialysis, advanced cardiovascular life support, and mechanical ventilation (Johnstone, 2004). Medications such as inotropes and vasopressors (used to improve cardiac function and provide hemodynamic support) are also administered in ICUs to help enable patients' lives to be sustained for extended periods of time (McClendon & Buckner, 2007). Patients can be dependent on these treatments, using them for breathing and preserving organ functions (Ulrich & Mooney-Doyle, 2012).

Given that patients in ICUs are critically ill, these units allow for continuous observation of patients and monitoring of cardiac, respiratory and brain functions (CCCS, 2014). Nurse to patient ratios are usually either 1:1 or 1:2 depending on the patients' requirements of nursing care (Kroh & Hurlock-Chorostecki, 2009). These staffing ratios enable critical care nurses to work in close physical proximity to their patients.

ICUs are made functional by multidisciplinary teams (Canadian Association of Critical Care Nurses [CACCN], 2009). Critical care nurses work in collaboration with other healthcare professionals such as physicians, respiratory therapists, occupational therapists, physiotherapists, social workers, speech language pathologists, dieticians, and spiritual care workers. Through this multidisciplinary collaboration, the care of patients and their families is coordinated so that their biopsychosocial-spiritual needs are addressed and met (CACCN, 2009).

Within ICUs, patients' wishes in relation to their plan of care are often unknown due to the suddenness and severity of their illnesses (St Ledger et al., 2013). In a study with 851 ICU patients who were receiving mechanical ventilation, the majority of them (79.8%) were unable to be involved in any decision-making during the first 24 hours of their admission to the ICU (Cook

et al., 2003). Consequently, it is often substitute-decision makers who must make clinical decisions on the behalf of ICU patients (Wallen & Baker, 2012). These decisions may not always reflect patients' wishes accurately.

2.2 Critical Care Nursing

The CACCN (2009) recognizes critical care nursing as a specialty where nurses with specialized education care for patients with life-threatening illnesses using a patient and family centered approach. To properly care for patients in the ICU, critical care nurses must be able to make comprehensive clinical judgements about the care that patients need (CACCN, 2009). They require advanced problem-solving skills and knowledge about human responses to critical illnesses (CACCN, 2009). Given the technological nature of the ICU, critical care nurses must balance the need for technology with the need of safety, dignity, comfort and privacy of the patients they care for (CACCN, 2009).

To outline the expectations of critical care nurses in Canada, the CACCN (2009) has articulated seven practice standards which critical nurses should follow. These practice standards have been presented as follows (CACCN, 2009):

1. Critical care nurses use specific knowledge and advanced skills to promote optimum physiological balance for patients by continuously assessing and monitoring them.
2. Critical care nurses promote and foster the comfort and well-being of patients and families within an extremely technological environment.
3. Critical care nurses facilitate partnerships with patients and their families that are built on a basis of communication, collaboration, dignity, and respect.
4. Critical care nurses adhere to best practice standards and enact safety measures when caring for patients in a high-risk environment.

5. Critical care nurses assist patients and their families in transitioning treatments to target a peaceful death when life-sustaining treatments are no longer beneficial.
6. Critical care nurses promote collaboration between patients, families and other health care professionals.
7. Critical care nurses foster leadership by promoting a culture within their practice that values collaboration, safety, quality improvement, responsible resource utilization, and professional growth.

Critical care nurses are also expected to practice in accordance with the ‘Canadian Code of Ethics for Registered Nurses’ (Canadian Nurses Association [CNA], 2008a). The Code of Ethics acts as a foundation for ethical practice in nursing (CNA, 2008a). It describes seven different values and ethical responsibilities that nurses are expected to uphold:

1. “Providing safe, compassionate, competent, and ethical care” (p.8),
2. “Promoting health and well-being” (p.10),
3. “Promoting and respecting informed decision-making” (p.11),
4. “Preserving dignity” (p.13),
5. “Maintaining privacy and confidentiality” (p.15),
6. “Promoting justice” (p.17),
7. “Being accountable” (p.18).

According to the Code of Ethics, nurses must strive to conserve life, promote health, support a dignified death, and alleviate and prevent suffering (CNA, 2008a). They must also conduct themselves ethically in what they do and how they act within their practices because they must maintain a moral commitment to their patients (CNA, 2008a).

The expectation of critical care nurses to abide by the ‘Code of Ethics’ (CNA, 2008a) and practice standards (CACCN, 2009) can be problematic. It can create tension for nurses when they are placed in a position where they are unable to uphold these obligations due to factors outside of their control (such as the decisions of physicians and substitute decision-makers). This tension can in turn give rise to moral conflicts and distress for nurses.

2.3 Death in the Intensive Care Unit

Death is a universal phenomenon and making end-of-life comfortable for patients should be the goal of every nurse (Robley, 2008). According to the ‘Canadian Code of Ethics for Registered Nurses’ (CNA, 2008a), when caring for patients who are either terminally ill or dying, nurses are obliged to foster comfort and alleviate suffering to support a peaceful and dignified death. However, this goal is not always easily attainable in the ICU. Given that ICUs function to help critically ill patients survive (Hamric & Blackhall, 2007; St Ledger et al., 2013), a shift in the focus to end-of-life care may be perceived as inconsistent with the overarching objectives of the ICU. Death can even be viewed by physicians as a treatment failure within these units (King & Thomas, 2013).

In ICUs, death often occurs following a decision to discontinue life-sustaining therapies once a patient’s body has failed to respond to treatment (Efstathiou & Walker, 2014). Scientific advances over the last 100 years in medications, surgical techniques, diagnostic procedures and special treatments have significantly influenced the way that healthcare is delivered in ICUs (Burkhardt & Nathaniel, 2014). Therapies such as ventilators and artificial organs that can sustain life have substantially advanced within the last few decades (McClendon & Buckner, 2007). New drugs have also been developed that have enabled patients’ lives to be sustained for extended periods of time (McClendon & Buckner, 2007). With the availability of these advanced

medical treatments, diseases that were once considered fatal have become manageable or even curable (Ferrell, 2006). While they do have merit as they help save lives, alleviate suffering and improve the quality of life for some, debate arises as to whether these treatments prolong death for others (Burkhardt & Nathaniel, 2014) and are an obstacle when attempting to assist patients in achieving a comfortable, dignified death (Wallen & Baker, 2012).

Death in the ICU can be a complex, controversial matter that can create moral challenges for nurses. An infamous controversial example is the case of Mr. Rasouli, which raised the question all over Canada as to whether consent is required (from patients or their substitute decision-makers) for the withdrawal of treatments in end-of-life circumstances. Mr. Rasouli was a patient at Sunnybrook Health Sciences Centre in Toronto who was initially admitted for the removal of a benign brain tumour (Supreme Court of Canada [SCC], 2013). After the surgery, Mr. Rasouli developed meningitis and ventriculitis, leaving him in a persistent vegetative state (SCC, 2013). Since October, 2010, he was in a comatose state and kept alive by a mechanical ventilator in the Sunnybrook ICU (SCC, 2013). Mr. Rasouli's physicians concluded that all medical treatments had been exhausted and that ongoing medical interventions would cause harm and not provide any medical benefit as Mr. Rasouli had no hope in recovering (SCC, 2013). Mr. Rasouli's wife (and substitute decision-maker) opposed the physician's decisions because withdrawing care conflicted with Mr. Rasouli's religious beliefs (SCC, 2013). This case was drawn out to court as the physicians felt that continuing life-sustaining treatments for Mr. Rasouli was inhumane and that they had an obligation to advocate for him (SCC, 2013). The case was assessed by the Supreme Court of Canada in 2013 who ruled in favour of Mr. Rasouli's wife. This decision was made upon reviewing the Ontario Health Care Consent Act which clarified that under the act, "treatment" required consent from patients or their substitute

decision-makers (SCC, 2013). The withdrawal of care was deemed to be a treatment and therefore required consent before it could be completed (SCC, 2013). This ruling established that physicians in Canada could not unilaterally withdraw life-sustaining treatments without having consent from patients or their substitute decision-makers (SCC, 2013).

Within the case, the physicians felt that keeping Mr. Rasouli alive on a mechanical ventilator was causing him harm and was an inhumane act (SCC, 2013). Though no article has examined the Sunnybrook critical care nurses' experiences of caring for Mr. Rasouli, they were also likely impacted by this case. It was these nurses who had to care for Mr. Rasouli and implement treatments that the ICU team had deemed not to be in his best interests. These nurses would have been acting inconsistently with the expectations from the 'Code of Ethics' (CNA, 2008a) and practice standards (CACCN, 2009) as they would have been unable to promote Mr. Rasouli's well-being. The reality for critical care nurses is that these ethical issues surrounding end-of-life care arise within their practice and they have to face them.

2.4 The Concept of Moral Distress

2.4.1 Definition of moral distress.

The complex concept of moral distress has been a significant area of inquiry for many nursing researchers. It has been explored in a multitude of settings where nurses practice such as the military (Fry, Harvey, Hurley, & Foley, 2002), geriatrics (Piers et al., 2012), medical-surgical and acute care (Corley, Minick, Elswick, & Jacobs, 2005; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008; Zuzelo, 2007), psychiatry (Forchuk, 1991), and oncology (Raines, 2000). Despite the vast amounts of literature on the topic, there is no single definition of moral distress that has been agreed upon within the nursing discipline.

Before exploring the concept of moral distress, it is important to first distinguish the meaning of the term 'morals'. Morals are concerned with what is right, wrong, what should or ought to be done in a situation (Jameton, 1984). They are the values and beliefs that individuals are personally committed to, defend and follow within their lives (Jameton, 1984). They are influenced by an individual's religion, family, life experiences and cultural background (McClendon & Buckner, 2007; Riesch, VonSadvoszky, Norton, & Pridham, 2000). Since morals are subjective, not everyone will find the same situations to be a source of moral distress.

The term 'distress' also has an important meaning that contributes to the concept of moral distress. Stress and distress are terms that are often used interchangeably throughout the nursing literature. However, they each have specific attributes. Stress occurs when an element in the psychological, physical or social environment threatens the equilibrium of an individual (Appley & Trumbull, 1967). Lazarus and Folkman (1984) define psychological stress as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19). In contrast, psychological distress is defined as "the general concept of maladaptive psychological functioning in the face of stressful life events" (Abeloff, Armitage, Lichter, & Niederhuber, 2000, p. 556). Distress entails a change in one's emotional status, coupled with a perceived inability to effectively cope (Ridner, 2004). As compared to stress, distress is also more often linked to symptoms such as pain, suffering, misery, discomfort, and anguish (Distress, 2016; Ridner, 2004).

Within the nursing literature, philosopher Jameton (1984) has provided the first and most cited definition of moral distress. Jameton (1984) identified that moral distress occurs "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the

right course of action” (p. 6). Institutional constraints that can impede one’s ability to execute what is right include the power of physicians, institutional policies, laws, and unsupportive supervisors (Jameton, 1984). Jameton (1993) later acknowledged that his definition of moral distress was ambiguous since individuals often act when they are faced with obstacles.

Therefore, he elaborated upon the definition to distinguish between two types of distress: initial and reactive. Initial distress refers to the feelings of anger, frustration and anxiety experienced when individuals encounter institutional obstacles and conflicting interpersonal values (Jameton, 1993). Reactive distress then denotes the feelings experienced when individuals do not act upon or resolve their initial distress (Jameton, 1993).

Shortly after Jameton (1984) published his initial definition, Wilkinson (1988) sought to further conceptualize moral distress. To do so, Wilkinson (1988) recruited nurses from two different counties in the United States who worked directly with patients. The nurses were provided with a definition of moral distress and were asked to participate in the study if they had ever experienced it (Wilkinson, 1988). The final study sample consisted of 24 nurses, 12 of which had ICU experience (Wilkinson, 1988). Upon interviewing these nurses, Wilkinson (1988) found that there were four situations that commonly caused them to feel distressed: 1) prolonging the lives of those who were dying, 2) executing orders from physicians for terminally ill patients that were perceived as unnecessary, 3) lying to patients, and 4) working with physicians who were perceived to be providing incompetent or inadequate care. When faced with these situations, the nurses reported experiencing emotions such as anger, sadness, frustration, and guilt. Wilkinson (1988) then conceptualized moral distress as the “psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision” (p. 16). Factors that

constrained the participants' moral actions were both external and internal. External constraints included physicians, laws, organizational policies, and hospital administration (Wilkinson, 1988). Internal constraints included one's beliefs that they must follow orders, lack of courage, fear of losing a position, and self-doubt (Wilkinson, 1988).

While Jameton (1984; 1993) and Wilkinson (1988) have both provided definitions of moral distress that are frequently cited within the nursing literature, many other researchers have also sought to define the concept. Källemark, Höglund, Hansson, Westerholm, and Arnetz (2004) define moral distress as the "traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake" (p. 1083). Epstein and Hamric (2009) argue that moral distress arises from a "perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (p. 2). Comparatively, McCarthy and Deady (2008) describe it as an "umbrella concept that captures the range of experiences of individuals who are morally constrained" (p. 254).

More recently, Peter and Liaschenko (2013) elaborated on the concept of moral distress by examining it through a perspective that integrates moral agency. Moral agency is "a person's capacity to engage in deliberate actions that are morally relevant; i.e. touching on matters of right and wrong, good and bad, or just and unjust" (Carnevale, 2013, p. 36). According to Peter and Liaschenko (2013), moral agency is comprised of three different elements: moral identities, relationships and responsibilities. Moral identities are socially constructed and include what nurses care for, are concerned about and take responsibility for (Peter & Liaschenko, 2013). Moral relationships include the expectations and trust that exist between individuals (Peter & Liaschenko, 2013). Lastly, moral responsibilities are the actions that nurses are specifically

accountable for within their practice such as promoting health, preventing illness, restoring health and alleviating suffering (Peter & Liaschenko, 2013). Moral distress is then defined as “a reaction to the constraints of moral identities, relationships, and responsibilities of nurses that underlie these understandings and practices” (Peter & Liaschenko, 2013, p. 339). Essentially, when the elements of moral agency (moral identities, relationships and responsibilities) are threatened or constrained, moral distress can arise (Peter & Liaschenko, 2013).

Despite the many definitions of moral distress that exist within the nursing literature, controversy and debate surrounds the concept. Johnstone, Hutchinson, and Peter (2015) have disputed that moral distress is a flawed concept that should be abandoned within the nursing literature because it holds an assumption that when nurses experience it, their moral decision is ‘right’. However, it is insufficient to judge a course of action as being morally correct simply because it supports a nurse’s opinion (Johnstone et al., 2015).

2.4.2 Antecedents of moral distress.

Before a nurse can experience moral distress, there are certain factors that must first exist. Antecedents are the conditions that must be in place before the concept can occur (Rodgers, 2000). One of the antecedents of moral distress is nurses’ moral commitment to patients. It has been contended that nurses have a genuine concern for the well-being, beliefs, feelings and vulnerability of patients (Cronqvist et al., 2004). This claim is evident when considering that nurses strive to conserve life, promote health and alleviate suffering (CNA, 2008a; Carper, 1978). These nursing goals are ethical in nature as they entail preventing harm and benefiting the well-being of individuals. Nursing’s professional framework is built on the basis of maintaining moral commitments to patients (CNA, 2008a). Nurses’ relationships with patients have a moral focus since nurses strive to enact what is right for their patients (Bergum, 2004). When this

moral commitment to patients exists and cannot be upheld, moral distress can be the experienced outcome for nurses (Cronqvist et al., 2004; King & Thomas, 2013).

Another important antecedent of moral distress is the perception that one possesses knowledge of the right action. Both Jameton's (1984) and Wilkinson's (1988) definitions of moral distress hold the inherent assumption that moral distress occurs when individuals are unable to pursue the correct course of action. However, morals are subjective and differ amongst individuals. What one individual may perceive to be a correct course of action may not be concurrent with another's point of view. With the subjectivity of morals taken into consideration, moral distress arises when individuals face a moral conflict and *perceive* that they possess the knowledge of the right action. This perceived knowledge is what differentiates moral distress from related concepts such as moral uncertainty and moral dilemmas. Moral uncertainty occurs when an individual is unsure of what the moral issue is within a situation (Jameton, 1984). Moral dilemmas ensue when one is faced with a situation where two or more moral principles are competing that will each lead to a different course of action (Jameton, 1984). While moral uncertainty, moral dilemmas and moral distress share some characteristics, it is only moral distress that requires individuals to perceive that they are knowledgeable about what is morally correct.

Lastly, encountering a constraint that creates a moral conflict also precedes moral distress. According to Nathaniel's (2006) theory of moral reckoning, there are three different scenarios in which 'situational binds' (or moral conflicts) can occur for nurses. The first scenario is when nurses' core values and beliefs conflict with professional or institutional norms (Nathaniel 2006). When these conflicts exist, nurses can then experience moral distress from having to uphold professional or institutional norms instead of being able to implement actions

that are consistent with their own values and beliefs. The second scenario is when power imbalances influence a moral disagreement between decision makers (Nathaniel 2006). It is physicians and patients' substitute-decision makers who share the power to decide upon what treatments are implemented for patients who cannot vocalize their wishes. Therefore, when nurses believe that certain treatments are inconsistent with what a patient would have wanted, they can feel morally distressed (Nathaniel 2006). The third scenario is when deficiencies within the workplace cause patient care to be compromised (Nathaniel 2006). These deficiencies include staffing shortages, equipment problems, and unreasonable institutional expectations related to standards of care (Nathaniel 2006). When these deficits exist in the work environment, nurses may be unable to meet their own or others' expectations, which can cause them to experience feelings of guilt and distress (Nathaniel 2006).

2.4.3 Effects of moral distress.

Moral distress has been a topic of interest to many nursing researchers due to the consequences that it poses. By utilizing existing research on the topic, Corley (2002) proposed a theory of moral distress that encompassed its negative effects. Corley (2002) theorized that moral distress negatively affects nurses, patients and organizations. When subjected to moral distress, nurses can suffer, feel burnt-out, resign from positions, and/or leave the profession (Corley, 2002). As a result of their moral distress, nurses can distance themselves from patients and cease to advocate for them, resulting in suboptimal patient care (Corley, 2002). As the quality of nursing care declines, patient satisfaction decreases, leading to the reputation of the organization being perceived as negative (Corley, 2002). Furthermore, when nurses resign from positions, organizations develop high turn-over rates in staffing which can cause difficulty in recruiting new nurses (Corley, 2002).

Numerous studies have supported Corley's (2002) theory by validating the negative impacts that moral distress has on nurses' emotional, physical, and psychosocial well-being. Nurses' emotional well-being becomes affected because moral distress is associated with negative feelings such as anger, sadness, frustration, guilt, depression, disgust, self-doubt, disappointment, psychological exhaustion, grouchiness, irritability, and short-temperedness (Deady & McCarthy, 2010; Elpern et al., 2005; Gutierrez, 2005; McClendon & Buckner, 2007; Nathaniel, 2006; Sundin-Huard & Fahy, 1999; Wiegand & Funk, 2012; Wilkinson, 1988). Moral distress can also pose negative physical symptoms such as headaches, physical exhaustion, sleep disturbances, diarrhea, heart palpitations, and vomiting (Elpern et al., 2005; Fry et al., 2002; Gutierrez, 2005; Nathaniel, 2006; Wiegand & Funk, 2012; Wilkinson, 1988). Lastly, moral distress affects nurses' psychosocial well-being by potentially causing them to have decreased patience with their own families/friends (Gutierrez, 2005; McClendon & Buckner, 2007), question their spiritual and religious beliefs (Elpern et al., 2005; McClendon & Buckner, 2007), become increasingly cynical (Elpern et al., 2005), feel worthless, lose confidence (Fry et al., 2002), and modify their personal wishes towards their own health (such as ceasing to donate blood and refusing to become an organ donor) (Elpern et al., 2005; Gutierrez, 2005).

Moral distress can also negatively impact nurses' professional lives. When nurses experience moral distress, they can: feel powerless in their positions (Barlem, Lunardi, Lunardi, Tomaschewski-Barlem, & da Silveira, 2013; Deady & McCarthy, 2010; Elpern et al., 2005; Gutierrez, 2005; Nathaniel, 2006; Sundin-Huard & Fahy, 1999; Wiegand & Funk, 2012; Wilkinson, 1988), become reluctant to come to work (Elpern et al., 2005; Gutierrez, 2005), feel ineffective, have difficulty concentrating (McClendon & Buckner, 2007), and withdraw emotionally and physically from other workers (Gutierrez, 2005).

2.5 Sources of Moral Distress for Critical Care Nurses

Critical care nurses work in a position that makes them vulnerable to moral distress (Beumer, 2008). As previously stated, nurse to patient ratios are often either 1:1 or 1:2 in the ICU (Kroh & Hurlock-Chorostecki, 2009). Critical care nurses therefore spend an extensive amount of time at the bedside of their patients. While other healthcare providers can leave the bedside, nurses must remain there to monitor and observe patients (McAndrew, Leske, & Garcia, 2011; Peter & Liaschenko, 2004). With their constant bedside presence, critical care nurses are increasingly aware of the symptoms of their patients (Hamric & Blackhall, 2007). Furthermore, they can feel tremendous amounts of distress as they are exposed to the pain and suffering of patients who are dependent on life-sustaining therapies for extended periods of time, ranging from weeks to months (Meltzer & Huckabay, 2004). Being the provider and assessor of care in these circumstances can be laden with emotion with the potential of causing nurses to experience distress (Ulrich & Mooney-Doyle, 2012).

To capture the sources of moral distress that exist, Corley, Elswick, Gorman, and Clor (2001) developed the Moral Distress Scale (MDS). The MDS is a 32-item questionnaire that presents different morally challenging situations and respondents use a seven-point Likert scale to rate the frequency that each situation causes them moral distress and the intensity of moral distress that it incurs. To develop the items on the scale, Corley et al. (2001) reviewed existing research to distinguish what moral problems arose in hospitals due to institutional constraints. These moral problems were then categorized into three different factors: ‘individual responsibility’, ‘not in the patient’s best interests’, and ‘deception’ (Corley et al., 2001). ‘Individual responsibility’ includes what nurses are responsible for but cannot influence because of institutional constraints such as working with inadequate resources or unsafe levels of staffing

(Corley et al., 2001). The second factor, 'not in the patient's best interests', includes acts that do not benefit patients such as implementing orders for tests perceived as being unnecessary and initiating life-sustaining treatments that prolong death (Corley et al., 2001). Lastly, the factor of 'deception' refers to actions that are meant to deceive patients such as when physicians prescribe the intravenous forms of medications when patients have refused them orally (Corley et al., 2001).

Quantitative and qualitative studies that have explored the sources of moral distress amongst critical care nurses have supported the three factors identified by Corley et al. (2001). The most common sources of moral distress for critical care nurses have been found to be related to: prolonging patient suffering and death with seemingly futile interventions (Browning, 2013; Choe et al., 2015; Cronqvist et al., 2004; Elpern et al., 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Mobley et al., 2007; Shorideh et al., 2012; Wiegand & Funk, 2012), carrying out orders for tests and treatments that were perceived as unnecessary for terminally ill patients (Ganz et al., 2013; McAndrew et al., 2011; Mobley et al., 2007), working with inadequate/unsafe levels of staffing (Browning, 2013; Choe et al., 2015; McClendon & Buckner, 2007; Shorideh et al., 2012), and assisting physicians who were providing incompetent care (Browning, 2013; Ganz et al., 2013; McAndrew et al., 2011). Within all of these aforementioned studies, moral issues that involved end-of-life care were the most frequently articulated source of moral distress for critical care nurses. Little information was provided, however, within these studies about how nurses coped with the moral distress that they experienced from these sources.

2.6 Coping with Moral Distress

2.6.1 Strategies from professional nursing organizations.

Though moral distress is recognized as a serious issue within the nursing profession (American Association of Critical-Care Nurses [AACN], 2008), few professional nursing organizations have articulated ways that nurses can cope with the experience. One organization that sought to do so was the AACN (2004) who published an article entitled “The 4A’s to Rise above Moral Distress.” The AACN (2004) outlined a staged process of asking, affirming, assessing and acting that nurses can follow to address their moral distress. In the first stage, nurses become aware of their moral distress by asking themselves and others whether they are showing any signs of distress (AACN, 2004). Next, nurses affirm their moral distress by validating their feelings and recognizing their professional responsibility to act upon their distress (AACN, 2004). In the third stage, nurses assess the specific source of their distress, determine the severity and then contemplate how ready they are to implement actions to resolve it (AACN, 2004). Lastly, nurses plan and employ strategies that will enable them to act upon their distress (AACN, 2004). A critique of the strategies identified by the AACN (2004) is that there is an assumption that nurses will resolve their moral distress when engaging in the 4A process. As a result, the AACN (2004) neglects to discuss how nurses can cope with their moral distress when it continues to prevail despite their attempts of acting to resolve the issue. This article is also 12 years old. Throughout these last 12 years, a multitude of studies have been completed that have revealed that moral distress is a serious issue within nursing that must be addressed (Browning, 2013; Choe et al., 2015; Cronqvist et al., 2004; Elpern et al., 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Mobley et al., 2007; Shorideh et al., 2012; Wiegand & Funk, 2012). Despite what the research has shown, the AACN

has taken no further action to publish articles aimed at helping nurses in dealing with the moral distress that persists in this area of clinical practice.

Similar to the AACN (2004), the CNA (2003) has also outlined a process for nurses to follow when responding to morally distressing situations. This process includes recognizing moral distress, referring to the 'Code of Ethics for Registered Nurses' and requesting support. When recognizing moral distress, nurses become aware of their feelings and are able identify what they are experiencing (CNA, 2003). The CNA (2003) contends that when nurses are able to label what they are experiencing as moral distress, they are more likely to resolve it as opposed to using negative coping strategies such as distancing and escape-avoidance. Next, the CNA (2003) advises that nurses should refer to the 'Code of Ethics for Registered Nurses' to help them clarify their ethical concerns, recognize their values and professional responsibilities, and reflect upon actions they could take to resolve their moral distress. Lastly, the CNA (2003) claims that nurses can relieve their moral distress by articulating their concerns and requesting support from others such as peers, the healthcare team, ethics committees, nurses' associations, and nursing unions. Though the outlined strategies of recognizing, referring and requesting can be effective for nurses to initially respond to their moral distress, the CNA (2003) fails to describe how nurses can cope with their distress when it continues to endure. Similar to the critique of the AACN, the CNA also has not published any more recent articles to help nurses with the moral distress that they may experience.

2.6.2 Coping in critical care.

Three studies were identified wherein research was conducted within the context of critical care that described how nurses cope with their moral distress. The first of these studies was a descriptive qualitative study conducted by Gutierrez (2005). Twelve nurses from a surgical

ICU in the United States were interviewed and asked to describe their experiences of moral distress (Gutierrez, 2005). Gutierrez (2005) noted that the nurses within the study possessed a sense of obligation towards maintaining what was right within their practice. To cope with their distress, the nurses would seek support from other nurses, family and friends (Gutierrez, 2005). Management was never cited as a source of support and most nurses believed that management was unaware of the distress that they experienced (Gutierrez, 2005). The predominant coping strategies that the nurses used enabled them to escape or avoid the source of their distress. For example, when patient circumstances were distressing, the nurses reported that they coped by decreasing their interactions with the patient and providing less personalized care (Gutierrez, 2005). While Gutierrez's (2005) study made mention of nurses coping strategies, it was not focused on this topic. Rather, its main emphasis was to highlight nurses' experiences with moral distress. Due to this reason, significant details were not provided regarding the identified coping strategies. This study also did not provide descriptions of the settings in which the participants worked or the contexts of patient care. The transferability of the study's findings to other settings is therefore limited.

In another study, McClendon and Buckner (2007) sought to describe nurses' experiences of moral distress and their coping strategies. McClendon and Buckner (2007) used mixed-methods that involved a quantitative portion of administering the Moral Distress Scale (MDS) and interviewing nurses using descriptive qualitative methods. The sample of the study consisted of nine surgical ICU and coronary care unit nurses in the United States. The MDS revealed that as a nurse's age increased, moral distress levels decreased, possibly meaning that over time the nurses "learned to cope more effectively" (McClendon & Buckner, 2007, p. 204). Another explanation as to why the experienced nurses had decreased levels of moral distress could be that

they were less morally engaged in their practice as compared to less experienced nurses. When faced with moral distress, the nurses in the study reported that they coped by utilizing proactive strategies such as connecting with friends, family, co-workers and supervisors so that they could verbalize their concerns and obtain support. Other maladaptive strategies or perhaps examples of being less morally engaged included distancing themselves from the moral issue and accepting that the situation was outside of their control (McClendon & Buckner, 2007). While some nurses felt that these coping strategies were helpful, others reported that they were either ineffective or only helped to a small degree (McClendon & Buckner, 2007). These participants were left feeling guilty, especially when nothing was done to improve the situation (McClendon & Buckner, 2007). A limitation of McClendon and Buckner's (2007) study was that the authors mentioned that with experience, nurses could "learn" to cope with moral distress, but did not provide any details on what this process entailed. Also, the authors noted that some of the participants found their coping mechanisms to be ineffective for them when dealing with moral distress. No elaboration was provided however on how the participants were impacted when they could no longer cope "effectively".

The third and most recent study that revealed how critical care nurses cope with moral distress was conducted by Wilson et al. (2013). The study sought to examine the level and frequency of moral distress in nurses and determine ways of addressing the experience (Wilson et al., 2013). A descriptive questionnaire was employed that included the MDS, a coping questionnaire, and questions about methods of support when managing morally distressing situations (Wilson et al., 2013). The sample included 50 nurses employed within medical-surgical ICUs and transitional care units in the United States (Wilson et al., 2013). The nurses rated their moral distress levels as being relatively low but some did indicate that they had left

positions in the past because it had impacted their personal lives (Wilson et al., 2013). Wilson et al. (2013) did not further elaborate upon how their personal lives were impacted and what coping strategies they used to manage these impacts. When asked what resources they would use to cope with their moral distress at work, the nurses most frequently identified seeking the ethics committee and debriefing (Wilson et al., 2013). However, nurses could only choose what resources they used to cope from a list provided by the authors. This list consisted of the ethics committee, counselling, online education, end-of-life protocols, debriefing, and workshops (Wilson et al., 2013). The participants therefore had only a finite number of options to choose from when it came to describing their coping strategies. No further explanation was provided by the authors as to why these specific options were selected to be presented on the questionnaire. Wilson et al. (2013) also chose a convenience sample of critical care nurses for the study; they did not purposively select participants who self-identified as having experienced moral distress. Purposive sampling would have enabled the authors to target nurses who had personally experienced moral distress so that a greater understanding could be generated as to how they lived through and coped with the experience.

2.6.3 Coping outside of critical care.

Outside of the context of critical care, a few studies have been conducted that have revealed nurses' strategies of coping with moral distress. One of these studies was completed by Deady and McCarthy (2010) who used descriptive qualitative methods to identify what situations cause moral distress and describe how nurses cope. The sample for the study consisted of eight Irish psychiatric nurses (Deady & McCarthy, 2010). The most common strategies the nurses used to cope were evasive and included avoiding the moral issue, changing jobs and forming a new personal moral code to follow at work that differed from what they followed at home

(Deady & McCarthy, 2010). On occasion, the nurses would challenge the ethical issues they faced, but only when they believed it was safe to do so (depending on how threatened they felt by the source of distress). Deady and McCarthy (2010) noted that for the nurses to continue working, it appeared to be essential that they distanced themselves from the issue that was causing them distress. This study was conducted amongst nurses working within a psychiatric unit where common sources of moral distress included mental health laws and the use of coercive practices with mentally ill patients (Deady & McCarthy, 2010). These sources differ substantially from the common situations that cause moral distress for critical care nurses.

Barlem et al. (2013) also revealed that nurses often withdraw to cope with their moral distress. The authors conducted a qualitative study with 15 nurses in Brazil from a university hospital to explore their resistance strategies when faced with moral distress. The nurses reported that when they would encounter morally distressing situations, they coped by accepting that the situation could not be altered (Barlem et al., 2013). In turn, they became withdrawn within their practice (Barlem et al., 2013). Eventually, the nurses would reach a point where they believed that nursing was a profession that entailed sacrificing one's values and began to simply follow orders and institutional policies (Barlem et al., 2013). Other ways that the nurses coped with their distress included seeking professional qualification and training, and changing routines and protocols (Barlem et al., 2013). No explanation was provided however by Barlem et al. (2013) as to what seeking professional qualification and changing routines meant and how it related to coping.

In a more recent study, Zavotsky and Chan (2016) examined the relationship between moral distress and coping with emergency department nurses using a descriptive correlational design. The questionnaire that the authors administered included the MDS and a COPE inventory

(used to measure coping strategies) (Zavotsky & Chan, 2016). A convenience sample of 198 emergency department nurses in the United States was surveyed for the study. The results of the questionnaire revealed that the participants used both ‘adaptive’ and ‘maladaptive’ strategies to cope with distress. The ‘adaptive’ strategies included using humour and accepting the situation as it was (Zavotsky & Chan, 2016). The ‘maladaptive’ strategies included morally disengaging within practice and abusing substances (Zavotsky & Chan, 2016). However, no further details were provided by the authors as to what these strategies consisted of. Another limitation of this study was that a convenience sample of emergency department nurses was used. Nurses did not have to self-identify as having experienced moral distress to be part of the study. Therefore, the phenomenon was not explored amongst a sample that identified as having first-hand experience with it. Lastly, no details were provided about the settings and contexts in which the participants practiced. It is therefore difficult to generalize the results of this study to other settings.

2.7 Summary of the Literature

The context of the ICU can be a distressing practice environment for nurses. As medical technology has improved and life-sustaining therapies have advanced, critical care nurses are finding themselves increasingly facing moral challenges within practice. While life-sustaining therapies do have significant merit and can be beneficial in improving the quality of life for some patients, their use can cause nurses to question their actions in certain cases. In particular, for patients with life-limiting illnesses who are thought not to be improving, nurses can perceive these therapies as causing undue suffering and prolonging the dying process. Critical care nurses are expected to abide by the ‘Code of Ethics’ (CNA, 2008a) and practice standards (CACCN, 2009) to conserve life, promote health, support a dignified death, and alleviate and prevent suffering (CNA, 2008a). However, tension can be created for them when situations such as

prolonging death place them in a position where they are unable to uphold these obligations.

When these situations cannot be altered, their moral values can become compromised, which can lead to the experience of moral distress. Though issues surrounding end-of-life care and futility most commonly cause moral distress, other sources such as working with unsafe levels of staffing and inadequate resources can also create moral issues for nurses.

Numerous studies over the last two decades have been completed that have shown that ICU practice can be significantly morally distressing for critical care nurses. Despite the vast amount of research on this phenomenon, little focus has been given as to how critical care nurses cope with their distress. Professional organizations such as the AACN (2004) and the CNA (2003) recognize that moral distress is an issue within nursing practice, but have taken no recent action to publish articles aimed at helping nurses deal with the experience. Other studies that have explored the experience of coping with moral distress have continually found nurses employ evasive strategies as a means of coping. These strategies entail escaping or avoiding the distressing issue without confronting it. The risk with these strategies is that nurses can become withdrawn and morally disengaged within their practice, which can cause patients to receive less than optimal nursing care. Collectively, studies that have explored nurses' experience of coping with moral distress have been limited as they do not provide details about the process of coping and how nurses reach a point where their main method of coping is to morally disengage themselves. Gaps also existed within these studies in identifying how nurses can use proactive strategies to cope with their distress so that they remain morally engaged in their practice. These gaps need to be addressed to allow for an in-depth understanding of the process of coping with the experience of moral distress.

Chapter 3: Methods

This chapter will provide an overview of interpretive description as the study's research design, including the investigator's ontological and epistemological stance. In addition, the study's sample, setting, methods for data collection and analysis, and strategies employed to ensure rigor of the findings will be reviewed in detail.

3.1 Research Design

To explore how critical care nurses describe the experience of coping with moral distress, this study adopted a qualitative design that used Thorne's (2008) approach to interpretative description. Qualitative research allows for knowledge related to human phenomena to be generated with great depth (Thorne, 2008). Through the collection of information in narrative form, qualitative research enables a phenomenon to be investigated in a holistic manner (Polit & Beck, 2012).

Thorne, Kirkham, and Macdonald-Emes (1997) developed interpretive description to allow researchers to generate knowledge within the context of nursing without having to strictly adhere to traditional qualitative methodologies such as phenomenology, ethnography and grounded theory. As a research approach, interpretative description drives the investigator to engage with the data beyond what is apparent (based on what has been assumed or previously established) (Thorne, 2008). Rather, it allows for the investigator to develop new insights related to the topic of inquiry (Thorne, 2008). It enables the investigator to discover what relationships and patterns exist within a phenomenon to understand what will likely be encountered in future practice (Thorne, 2008). Findings of interpretive description studies are then based on inductive reasoning where observations made lead to broader generalizations (Thorne, 2008). Since its development, many nursing researchers have opted to use interpretive description as a method to

generate nursing knowledge. This method allows for researchers to address complex questions related to human experience and create knowledge that can inform clinical nursing practice (Thorne, Kirkham, & O’Flynn-Magee, 2004).

Interpretive description studies often rely on narratives as sources of data (Thorne, 2008). By engaging with participants through the use of semi-structured interviews or focus groups, participants’ experiences are revealed and their subjective knowledge about the phenomenon of interest is uncovered (Thorne, 2008). The investigator then attempts to understand these experiences (Thorne, 2008).

The ontological underpinnings of interpretive description are aligned with Lincoln and Guba's (1985) naturalistic inquiry paradigm. A paradigm refers to a lens that is used to view and interpret issues related to a discipline (Weaver & Olson, 2006). Within the naturalistic inquiry paradigm, the nature of reality (ontology) consists of realities that “are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature” (Guba & Lincoln, 1994, p. 110). Essentially, the naturalistic inquiry paradigm is based on the assumption that reality does not exist as an objective entity; rather, it is a socially constructed phenomenon and is experienced subjectively by the individual (Lincoln & Guba, 1985). However, elements of reality can be shared amongst individuals or within groups (Guba & Lincoln, 1994). Interpretive description emphasizes human commonalities and individual variations (Thorne, 2008). Consistent with the epistemological considerations of naturalistic inquiry, interpretive description recognizes that there is a relationship between the inquirer and the participant since they interact and influence one another (Thorne, 2008). Within this interaction, “findings are literally created” as the study progresses (Guba & Lincoln, 1994, p.

111). As a result, knowledge is created between investigators and participants (Guba & Lincoln, 1994).

Within this study, interpretive description allowed for an understanding of the subjective realities of critical care nurses who have coped with moral distress. Moral distress is a subjective experience since not all nurses will find the same situations to be distressing (Wilkinson, 1988). Therefore, this research approach enabled the investigator to comprehend individual nurses' realities and experiences, as well as the commonalities that they shared between them. Interpretive description guided the investigator to move past solely describing nurses' reported experiences. As such, the investigator was able to interact with the participants, uncover and interpret the themes and patterns associated with the phenomenon of interest, and create knowledge. The investigator was also keenly aware of all personal experiences possessed related to the phenomenon of interest so that any biases could be minimized.

3.2 Methodological Assumptions

There are two main methodological assumptions for interpretive description studies. The first assumption is that participants are experts in the topic of inquiry due to their experience with the phenomenon of interest (Thorne, 2008). The second assumption relates to the role of the investigator. Thorne (2008) recognizes that there is difficulty in describing a phenomenon without acknowledging one's presumptions (Thorne, 2008). Therefore, prior to a study, investigators must engage in "theoretical scaffolding" (Thorne, 2008, p. 54). Theoretical scaffolding is the process in which one recognizes the background knowledge that will be brought into the study (Thorne, 2008). It consists of two elements: recognizing conclusions drawn from the literature and locating oneself (Thorne, 2008). The first element entails completing an extensive literature review to become knowledgeable of the current state of the

phenomenon of interest and draw conclusions. The second element, locating oneself, requires investigators to self-reflect upon how their knowledge, assumptions, values and beliefs will play a role in shaping the study. Thorne (2008) explains that investigators must be mindful of these factors, bring them forward to the surface and reflect on how they will be influenced by them when designing and implementing the study. If any new ideas, thoughts, perspectives or experiences arise throughout the study that will influence the investigator, they must be noted so that they can be managed and accounted for (Thorne, 2008). Investigators must also locate themselves within their discipline so that they can understand its scope and philosophical underpinnings to identify what constitutes as knowledge (Thorne, 2008). Lastly, investigators must also locate their theoretical allegiances (Thorne, 2008). Thorne (2008) explains that interpretive description studies do not require a theoretical structure. However, if investigators do locate themselves within a theoretical framework, it must not be used superficially. Rather, it must be explicated and used consistently to guide research decisions and design (Thorne, 2008). For the purposes of this study, the investigator chose not to structure the study with a theoretical framework so that the phenomenon of interest could be studied without imposing any pre-existing structures and perceptions upon it. By doing so, the investigator was able to draw conclusions from the data analysis inductively.

3.3 Theoretical Scaffolding Process

When engaging in theoretical scaffolding, investigators must locate themselves, be aware of who they are, what they represent, and what their motivation for the study is (Thorne, 2008). I locate myself within the nursing discipline which I believe has a philosophical assumption that nurses are moral agents who have a moral commitment to their patients. As moral agents, nurses are morally engaged in their practice and therefore have the capacity to direct their actions

towards what is right, just and good (CNA, 2008a; Carnevale, 2013). My nursing experience has been predominantly within critical care; specifically, within the coronary care unit. When first transitioning into critical care, I quickly became aware of the ethical issues that arise within these types of units and how one's moral values about what is right and wrong in nursing practice can become challenged. I have experienced moral distress on many occasions due to cases involving prolonging patient suffering and physician hesitancy to discuss death with patients' families. For example, I have performed CPR on a 96 year old patient because his code status and treatment wishes had not yet been discussed with the medical resident. I have also witnessed as life-saving interventions were performed on a patient based on his family's consent that were inconsistent with his previously stated wishes. In these situations, I had colleagues who empathized with me, but otherwise I felt as though there was no support within the work environment to help me cope with what I was experiencing. When examining the nursing literature, I found that numerous studies have repeatedly shown that the ICU is a practice environment that can pose moral challenges and cause significant amounts of distress for nurses. However, I could not find details as to how nurses cope when faced with these moral challenges. Thus, I become motivated to conduct a study exploring nurses' experiences of coping with moral distress in order to facilitate support.

Prior to conducting the study, I reflected upon my assumptions and beliefs about nurses' experiences of coping with moral distress. These assumptions are based upon my personal experiences, as well as existing nursing literature that I have reviewed. They are as follows:

1. Critical care nurses regularly experience moral distress due to conflicts with physicians, prolonging patient death, and inappropriate use of health care resources.

2. Moral distress may not only have detrimental effects on critical care nurses' professional lives, it also may impact their personal lives.
3. When critical care nurses experience moral distress, common sources of support for them are other empathetic nurses.
4. Critical care nurses may physically and mentally distance themselves from sources of moral distress as a means of coping.

3.4 Setting

This study took place in two ICUs located on two different campuses of a tertiary care academic hospital located in a large, urban city in Ontario. This hospital has multiple sites, approximately 12,000 staff members and 1,100 patient beds. The ICU at site A contains 33 patient beds and the other ICU at site B has 32 patient beds. Patient care on these units is provided by a multidisciplinary team that consists of ICU physicians, medical residents, registered nurses, respiratory therapists, social workers, pharmacists, physiotherapists, dieticians, occupational therapists, speech language pathologists, and spiritual care providers. These team members collaborate together to help meet patients' holistic needs. Both of these ICUs are equipped to care for critically ill patients that require specialized medical-surgical services, but site A specializes in neurological, vascular and trauma care while site B specializes in cancer, burn, respiratory and thoracic care. Apart from specializing in certain medical services, no significant differences exist between the two sites. There has been no indication in the nursing literature that the types of medical services offered in the ICU have an effect on nurses' experiences of moral distress. Both ICUs share a purpose of providing intensive resuscitation, treatment and monitoring to critically ill patients. The multidisciplinary team structure, protocols, policies and procedures are generally consistent across the sites and corporate structure.

3.5 Sample

Qualitative studies often have sample sizes that range from five to 30 participants, but the size is dependent on the complexity of the research question (Thorne, 2008). Sandelowski (1995) emphasizes that qualitative studies should focus on the quality of the data collected rather than the sample size. The sample of this study consisted of seven critical care nurses from two ICUs of a tertiary care hospital. Qualitative studies that have explored how nurses cope with moral distress have also had fairly similar sample sizes (Deady & McCarthy, 2010 [n=8]; Gutierrez, 2005 [n=12]); McClendon & Buckner, 2007 [n=9]). According to Lincoln and Guba (1985), once no new meaningful data is collected, sampling and data collection can cease. Therefore, the sample size was continuously reassessed as the study progressed until rich descriptions of the phenomenon of interest with numerous comments and examples were generated (Munhall, 1994).

3.5.1 Eligibility criteria.

Purposive sampling was employed since interpretive description studies seek participants who have experienced the phenomenon of interest (Thorne, 2008). The eligibility criteria selected was broad enough to enable the majority of the nurses from the two ICUs to participate in the study, while also ensuring that participants had still experienced the phenomenon of interest. The selected inclusion criteria were the following:

1. Be a registered nurse employed full-time or part-time in the ICU,
2. Have completed orientation,
3. Have had at least one experience of feeling morally distressed at work,
4. Be able to speak English or French.

Having completed orientation was selected as a criterion to ensure that participants had sufficient time to have been exposed to the phenomenon of interest. Participants were also required to personally feel that they had experienced moral distress on at least one occasion so that they could share their experience with the investigator. To describe moral distress, Jameton's (1984) definition of the concept was presented on the documents used to recruit participants (the Research Ethics Board required a definition to be provided). This decision was made since Jameton's (1984) description is the most cited definition of moral distress that exists within the nursing literature. However, given that there is no consensus on a single definition of the concept, nurses in this study were also asked what moral distress meant to them.

3.5.2 Recruitment.

To recruit participants, the investigator met with the clinical director, program director and managers of the two ICUs to explain the study's purpose, aims, and methods, as well as to ask permission to conduct the study and seek guidance on how to recruit participants without disrupting the units. Written permission was obtained by the clinical director and program director as part of the ethics review procedure. Once ethics approval was received by the Research Ethics Boards of the hospital and the university, the site investigator initiated recruitment by distributing flyers within the units on bulletin boards and in staff lunch rooms. These flyers described the study's purpose, data collection methods, inclusion criteria (see Appendix A and B), and requested for nurses to contact the investigator via e-mail or phone if they were interested in participating. The site investigator also asked the research coordinators at each ICU to e-mail a summary of the flyer to all the nurses employed within the units (see Appendix C and D). The flyer and e-mail summary were translated by the investigator into French so that Francophone nurses could also participate in the study. Nurses who were

interested in participating then contacted the investigator and were provided with information about the study. An interview at a convenient time and within a private room at the hospital was then scheduled.

In the interview, participants were provided with the Information/Consent Form (see Appendix E and F) that explained the study's aims/purpose, methods for data collection, and associated risks. These forms also described what participation entailed and how their information would be kept confidential. The investigator reviewed the Information/Consent Form with each participant and answered any questions that arose. If participants then chose to proceed with the study, they were asked to sign two copies of the Information/Consent Form, one which they retained and the other was kept by the investigator. Participants were also asked to choose a pseudonym to be referred to in the study so that their identity would remain confidential.

3.5.3 Participant characteristics.

Seven nurses participated in the study, all of whom were Caucasian females. Their demographic data was grouped to ensure that their anonymity was maintained. All of the participants were English speaking. Three of the participants were recruited from Site A and three from Site B. The seventh participant worked as a resource nurse who would work equal hours between both units. The participants' years of nursing experience ranged from eight months to 35 years. The median years of experience was five years. Years of critical care nursing experience ranged from eight months to 27 years and the median was two years. Of the seven participants, five had three years or less of ICU experience (potential reasons to explicate the sample's experience levels will be further discussed in chapter 5). In regards to education, all of the participants possessed a Bachelor's degree in nursing and one had a Master's degree.

3.6 Data Collection

Once informed consent was obtained, face-to-face, semi-structured interviews were conducted with each participant in a private room within the hospital campuses that they worked at. These interviews allowed for each nurse to recall and share personal experiences related to the phenomenon of interest.

Within the interviews, participants were first asked to reflect upon what moral distress meant to them (see Appendix G and H for interview guide). They were also asked to elaborate upon situations that provoked moral distress for them, what impacts moral distress had on them, what coping meant to them, and how they coped with distress. Though the interview guide was translated into French, all of the interviews were completed in English. Interviews were 30-80 minutes in length (with an average of 40 minutes) and audio-recorded. Verbatim transcription of each interview was completed.

To enhance the data that was collected from the interviews, the investigator wrote field notes. Field notes account for details that cannot be captured within an interview, including the perception of the environment and non-verbal communication (Morse & Fields, 1996). These field notes were completed privately at the end of each interview. The investigator also kept a reflective journal to note any personal beliefs and assumptions that arose throughout the study. This journal enabled the investigator to be continuously mindful of beliefs possessed related to the phenomenon of interest to minimize sources of bias on the study (Thorne, 2008).

3.7 Data Analysis

To analyze the collected data, thematic analysis was utilized. While interpretive description relies on inductive reasoning to make generalizations (Thorne, 2008), there are no formal methods to analyze data. Instead, Thorne (2008) notes that borrowing methods of analysis

from other qualitative designs will enhance the study. With this flexibility, investigators can move past solely describing a phenomenon and explore new ways of yielding meaning from the data (Thorne et al., 2004).

Within 24 hours of each interview, the investigator listened to the audio-recording to become familiarized with the participant's description of their experiences. The investigator then completed verbatim transcription. Upon completion, the investigator verified the transcript with the audio-recorded interview for accuracy. The investigator also compared the transcript to the collected field notes to add in any relevant non-verbal gestures.

Once the transcription was completed, the investigator immersed in the data by re-reading transcripts and listening to the audio-recorded interviews to become attuned to key patterns and cases that contrasted. The investigator then began to group the data and shifted from looking at individual interviews to the complete data set across all of the interviews.

Thematic analysis was completed using the steps outlined by Aronson (1995). Thematic analysis helps distinguish "identifiable themes and patterns of living and/or behavior" (Aronson, 1995, p. 1). The investigator began with reviewing the transcribed interviews to note what patterns of experience were described. The patterns that were identified were then categorized into separate folders. The investigator then determined which patterns were related and combined and catalogued them into sub-themes. Theme statements were then formulated which allowed for the development of a story line.

Once the data was analyzed, the investigator invited each of the participants to partake in a follow-up interview. Of the seven participants, four were able to meet with the investigator. These interviews were 10-15 minutes in length. The participants were asked to review the investigator's summary of the findings to ensure that the themes accurately captured their

experiences. The follow-up interviews showed participants the investigator's interpretations, and also presented a synthesis of what was learned so that they could reflect upon the extent that it was true to their experiences.

3.8 Methods to Ensure Rigor/Trustworthiness

Steps were taken to help ensure that rigor (or trustworthiness) was attained. Given that interpretive description aligns itself with naturalistic inquiry, Lincoln and Guba's (1985) four criteria to develop trustworthiness (credibility, confirmability, transferability, and dependability) were addressed.

3.8.1 Credibility.

Credibility describes the steps taken to ensure that there is confidence in the truth of the data (Lincoln & Guba, 1985). To enhance credibility, the investigator replayed each audio-recorded interview while reviewing the verbatim transcript to confirm that it was completed accurately. Follow-up interviews were also conducted with the participants to ensure that there was truth to the data and that the analyzed themes were reflective of their experiences. These interviews allowed for an opportunity to check the investigator's interpretations with the study's subjects (Thorne, 2008). The role of the investigator as a critical care nurse also contributed to credibility due to the personal knowledge possessed about the ICU environment. Lastly, members of the thesis committee were experts in critical care nursing and/or qualitative methods. As the study progressed, the investigator met with the committee regularly to discuss the data as it emerged.

3.8.2 Confirmability.

Confirmability refers to the extent that the study results from participants' experiences rather than the investigator's biases or suppositions (Lincoln & Guba, 1985). To increase

confirmability, the investigator explicated all beliefs and assumptions possessed towards the phenomenon of interest prior to the study and was mindful of them throughout the data collection and analysis process.

According to Lincoln and Guba (1985), confirmability is enhanced when multiple investigators have examined the data's meaning. The thesis supervisors, both experts in qualitative data analysis, assisted the investigator by developing the themes of the study after analyzing the interview transcripts.

3.8.3 Transferability.

Transferability alludes to the extent that a study's findings can be applied to other similar groups or settings (Lincoln & Guba, 1985). The investigator provided a detailed description of the setting. The investigator also collected the demographic characteristics (such as years of experience) of the sample. The research consumer can then determine whether this study's findings are applicable to other contexts (Lincoln & Guba, 1985). Moral distress has been shown within the nursing literature to widely affect critical care nurses. By detailing the setting, the findings of this study could be transferable to ICUs in other institutions.

3.8.4 Dependability.

Dependability denotes how stable the data remains over time and whether the findings would be reproducible if the study was replicated (Lincoln & Guba, 1985). Sandelowski (1986) remarks that a study is dependable when other investigators can use the "decision trail" of the investigator and obtain the same results (p. 33). Therefore, the investigator kept a detailed account of all methodological considerations and decisions. This audit trail created an explicit pathway that explicated the investigator's reasoning behind study-related decisions (Thorne, 2008).

3.9 Ethics and Human Participant Protection

To recruit participants, the investigator obtained approval to conduct the study from the managers, clinical director and program director of the two ICUs, as well as from the Research Ethics Boards of the hospital and university. Prior to data collection, participants were provided with the Information/Consent Form (see Appendix E and F) that explained the study's aims/purpose, methods for data collection, and associated risks. The investigator reviewed the Information/Consent Form with each participant and answered any questions that arose. The investigator emphasized that participation in the study was voluntary and that participants had the right to refuse to answer any questions or withdraw from the study at any time. A copy of the signed consent form was given to each participant.

To protect participants' rights and identities, all of their information was kept in a confidential manner. Prior to the interview, participants were asked to choose a pseudonym to be referred to in the study. Any information that could have potentially linked a quotation to a participant was removed from the findings. The audio-recorded interviews and transcripts were kept on a USB key that was encrypted and password protected. Upon completion of the data analysis, the audio-recorded interviews were deleted from the USB (as per the Research Ethics Board). The signed consent forms were kept securely in a locked cabinet in the thesis supervisor's office at the university. The interview material was only shared with the thesis supervisors and committee members. The signed consent forms and electronic interview transcripts will be kept for a period of ten years, after which the consent forms will be shredded and disposed in confidential waste and the electronic interview transcripts will be securely deleted.

Chapter 4: Findings

This chapter presents the shared experience of coping with moral distress, as described by seven critical care nurses. These nurses were employed in two medical-surgical ICUs located on two different campuses of a tertiary care academic hospital in a large, urban city in Ontario. This chapter will present an overview of the study's findings, followed by the themes. The major themes that are presented are consistent with the objective of the study which was to describe critical care nurses' experiences of coping with moral distress. To support the identified themes, direct quotes are used from the participants.

4.1 Overview of the Themes

The investigator identified that the shared experience of coping with moral distress could be explicated through four major themes: *Going Against What I Think is Best*, *Moral Distress: It's Just Inherent in Our Job*, *It Just Felt Awful*, and *Dealing with It*.

Going Against What I Think is Best represented the participants' descriptions of the concept of moral distress. It consisted of two subthemes: *Not Doing the Right Thing* and *I Knew What I Needed To Do*. *Not Doing the Right Thing* referred to completing an action that was inconsistent with one's perception of what was right. *I Knew What I Needed To Do* entailed possessing knowledge of the right thing to do.

The second theme, *Moral Distress- It's Just Inherent in Our Job*, revealed the sources that caused the participants moral distress. These sources were captured within five different subthemes: *Working with Uncertainty*, *Dealing with Miscommunication*, *Resonance*, *Questioning the Decisions of Others*, and *Prolonging Care*. *Working with Uncertainty* referred to the lack of clarity that existed within the participants' practices surrounding patients' wishes and prognoses. *Dealing with Miscommunication* involved situations where physicians would

withhold pertinent information from patients and/or their families, or would not relay messages appropriately between different physician teams. *Resonance* occurred when the participants related personally to their patients and/or their families. *Questioning the Decisions of Others* entailed feeling conflicted with the decisions of patients' families and physicians. Lastly, *Prolonging Care* encompassed prolonging the care of patients who were dying.

The third theme, *It Just Felt Awful*, included how the characteristics of moral distress impacted the participants' biopsychosocial health. These characteristics were separated into three different subthemes: *Emotional Characteristics*, *Physical Characteristics*, and *Psychosocial Characteristics*. *Emotional Characteristics* included the negative impacts that moral distress had on one's emotional health. The *Physical Characteristics* contained all of the consequences that moral distress had on the participants' physical health. The third subtheme, *Psychosocial Characteristics*, encompassed the impacts moral distress had on the participants' psychological and social well-being.

The final theme, *Dealing with It*, depicted how the participants coped with moral distress. Their coping strategies were separated into four subthemes: *Having an Outlet*, *Avoiding It*, *Connecting with Someone Who Gets It*, and *Getting Yourself Back Up*. *Having an Outlet* referred to the unique strategies used by the participants to release the emotions and stress that they experienced as a consequence of moral distress. *Avoiding It* referred to the coping strategies the participants used in which they avoided the morally distressing issue at hand. *Connecting with Someone Who Gets It* represented a strategy in which the participants sought and connected with others for support. Lastly, *Getting Yourself Back Up* depicted the coping strategy of reaching closure and moving forward from the morally distressing situation.

4.1.1 The overarching theme: Like grass in the wind.

The experience of coping with moral distress had an overarching theme of being *“like grass in the wind.”* Moral distress was a prevalent issue with many negative characteristics that led the participants towards questioning themselves and doubting whether they were doing the right thing. As Diana explained, this experience of moral distress is comparable to how zebra grass is affected by the wind. When strong winds blow, zebra grass is forced flat onto the ground. However, this grass seldom remains flattened. Instead, it is able to get back up, even when the strongest winds push it down. Diana described the zebra grass as follows: *“It’s beautiful tall grass. Grows 12 feet up to September, has a beautiful flower, and after all these winds, it’s an amazing plant... Every year it comes back. Even after the biggest winters.”* The wind is symbolic of the moral distress that would negatively affect the participants on emotional, physical, and psychosocial levels. Despite the hardship that moral distress would cause, the participants were able to use their skills, experience, and knowledge to work through the distress. They were assertive and held true to their nursing values. Just like the grass, their roots were firmly in place, so they were able to withstand adversity and get themselves *“back up.”*

4.2 Theme 1: “Going Against What I Think is Best”

The study participants explained that working in the ICU predisposed them to experiencing moral distress. They referred to the ICU as an area of practice that could be grim to work in because despite intensive clinical intervention, the reality of critical care was such that patients do not always recover from their illnesses. Incredible events did occur within their practice where patients with multiple, complex illnesses were able to be saved. However, the participants described that they were frequently exposed to death. When it came to knowing patients’ wishes regarding treatment plans, they would be faced with uncertainty as patients,

given the gravity of their illnesses and the nature of medical interventions required in critical care, were often not in a position where they could voice their concerns. As a result of the complexity of working in the ICU, the participants experienced moral distress and developed an interpretation of what the concept meant to them. *Going Against What I Think is Best* represented the participants' descriptions of the concept of moral distress. It consisted of two subthemes: *Not Doing the Right Thing* and *I Knew What I Needed To Do*. The first, *Not Doing the Right Thing*, referred to completing an action that was inconsistent with one's perception of what was right. The second, *I Knew What I Needed To Do*, entailed possessing knowledge of the right thing to do.

4.2.1 Not doing the right thing.

When asked what moral distress meant to them, every study participant spoke of *Not Doing the Right Thing*. They indicated that moral distress occurred for them when they performed an action that was inconsistent with their perception of what was right. This inconsistency would then form an inner conflict for them. There was a literal "*distortion*" between what was occurring within their practice and what their beliefs were. As Summer explained, "*I think moral distress means that you are faced with a situation and you don't necessarily believe that what you are doing is morally right.*"

The participants noted that deciding upon the right thing was highly subjective as their perception of what was right was influenced by their own values and beliefs. They identified that individuals all have unique, personal values that influence their perceptions. As a result, their values could differ from the values held by other important stakeholders responsible for decision-making such as patients and/or their families and physicians. In particular, they were cognizant that patients and their families could possess different cultural, spiritual and religious

beliefs with which they could disagree with. Working with these other stakeholders could then place the participants in a position where they would have to act in accordance with the beliefs of patients and/or their families and physicians as opposed to their own. They would then be left feeling conflicted and questioning whether what they were doing was right. As Diana explained, *“It’s having to deal with the difference between what they want and what you think is the right thing. Sometimes it’s that duality. I’ll call it the duality because it’s a conflict inside.”*

When feeling conflicted from *Not Doing the Right Thing*, the participants were also mindful that what they believed was right was not always necessarily the correct course of action. They reported that working in the ICU caused them to experience situations where they felt that they had to go against what they believed was best for patients. Their perception of what was best could however differ from those of patients and their families. For example, Janice stated, *“I’ll either feel frustrated that the doctors aren’t doing what I want them to do... Or the families aren’t making the decision that I think is right for so and so.”*

When a situation occurred within practice that the participants felt was not right, they indicated that they were not always immediately cognizant that they were experiencing moral distress. It had more of an insidious onset and took a while to identify. They would initially feel conflicted and as though there was something wrong about the situation, but were not able to necessarily pinpoint that it was in fact moral distress that they were experiencing. For Diana, moral distress initially presented itself when she would think, *“Oh my God. There is something, I don’t feel right with this. It’s not good.”* Upon critical reflection of the situation, Diana and the other participants were then able to identify that they were experiencing moral distress.

4.2.2 I knew what I needed to do.

When study participants described the concept of moral distress, they would mention, “*I knew what I needed to do.*” Moral distress most often occurred as a result of knowing what needed to be done but being unable to complete it. This knowledge of the right action was heavily influenced by the moral values that underpin the nursing profession that are articulated by the CNA (2008a) such as promoting the well-being and comfort of patients, respecting patient autonomy and informed decision-making, and supporting a dignified death. In order to possess knowledge of the right action, the participants first needed to identify what the patient’s wishes were. The participants were then committed to acting in accordance with these wishes, even in circumstances when it conflicted with their own beliefs. Julia stated, “*Because my patient might have different beliefs than I do so I would want to do everything I can to follow what their wishes are as opposed to just my own; what I believe to be their wishes.*” When patients were able to articulate their wishes, the participants respected and upheld them as they knew it was the right thing to do as opposed to following their personal beliefs.

Facilitating a comfortable end-of-life for patients and preventing and alleviating pain and suffering were also viewed by the participants as ethical obligations that must be upheld. These commitments of fostering comfort and promoting the well-being of patients are part of the roles and responsibilities for nurses that are outlined within the nursing practice standards of the College of Nurses of Ontario [CNO] (2009), as well as within the ‘Canadian Code of Ethics for Registered Nurses’ (CNA, 2008a). The nursing practice standards and Code of Ethics both help guide nurses in understanding what they are accountable for and what is expected of them (CNA, 2008a; CNO 2009). Though the participants did not blatantly say that their knowledge of the right action was derived from any nursing practice standard or the Code of Ethics, it appeared

that these sources served as a professional framework for which they based their practice on. Their moral judgments also seemed to have been derived from these two sources. For example, Valerie recalled a situation in which she cared for an agitated patient that she could not feed because he could not swallow. She was unable to insert a nasogastric (NG) tube into him to deliver feeds because the physician would not give her the order to do so. The physician's rationale was that the patient was so agitated that he would pull the NG out. She stated:

He was so agitated but he wouldn't...couldn't eat. We didn't have an NG tube in him and I just felt so horrible because he hadn't been fed in like 2 days. Like I couldn't get any PO [oral] meds into him, nothing. And all I wanted to do was just to get, you know, just feed him a little bit. Just give me a tool to get some meds into him. All I wanted to do was get a couple of feeds in him. Give me an NG so I can give him his meds to control his heart rate.

In response to the situation, Valerie described, *"It just felt awful. I felt like I knew what I needed to do but I couldn't do it because I didn't have the order."* Within Valerie's example, it was evident that she believed she was knowledgeable of what needed to be done, which was to determine a method in which the patient could be fed. Her moral judgement would have led to promoting the well-being of the patient. Instead, not enough was done and the patient's well-being was ultimately compromised. Knowing what needed to be done but being unable to attain it was a major factor that contributed to the participants' descriptions of moral distress.

4.3 Theme 2: "Moral Distress- It's Just Inherent in Our Job"

The theme *Moral Distress- It's Just Inherent in Our Job* revealed the sources that caused the participants moral distress. Feeling morally distressed was not rare or infrequent within the participants' practices. When asked to describe a situation that caused moral distress, Summer replied, *"I work in the ICU, it's all the time!"* The participants perceived moral distress as being

an “*inherent*” part of their job. They also described that it occurred quite habitually. It appeared to be an occupational hazard to which the participants were repeatedly exposed.

A variety of different situations (discussed in further detail below) were described to be major sources of moral distress and they all involved a common factor: patient care was somehow impacted. Within their practices, the participants worked in close physical proximity with their patients as there was usually a 1:1 nurse to patient ratio. Their shifts were 12 hours in length and they would often work two to four days in a row with the same patient. Given their proximity and recurring contact, their thoughts and emotions were concentrated towards their patients and their families, which predisposed them to experiencing moral distress when they believed that patient care was impacted. The different sources that caused the participants moral distress were captured within four different subthemes: *Working with Uncertainty*, *Dealing with Miscommunication*, *Resonance*, *Questioning the Decisions of Others*, and *Prolonging Care*.

4.3.1 Working with uncertainty.

Working in the ICU, the participants noted that they practiced within a realm of *uncertainty* that caused them to feel morally distressed. This *uncertainty* referred to the lack of clarity around patients’ wishes and prognoses. *Uncertainty* was an innate part of their practice to which they had to become accustomed. In many cases, patients were admitted to the ICU without any advanced directives and due to their respective illnesses, were in a position where they could not vocalize their wishes and concerns. Instead, patients’ families would articulate what they believed the patient’s wishes were. Distress for the participants arose when there were disagreements amongst family members regarding what accurately depicted what the patient would have wanted. In these circumstances, family members would provide different interpretations of the patient’s wishes. The participants experienced tension because their

knowledge of the right action became distorted. They were unable to identify which family member most accurately represented the patient's wishes. Therefore, it was difficult for them to distinguish what clinical decisions would lead to actions that would have best respected the patient's autonomy. As Christine explained:

...we have patients...a lot of times it's not very clear. We don't have a clear set of advanced directives, but you have a lot of hearsay from families. Like they'll be saying things like, 'Oh, he wouldn't have wanted this' or 'He would want this.' But you have a lot of different family members saying different things and you don't necessarily know the right thing. The patient is in no state to tell you what they would've wanted.

The participants were left with ambiguous representations of what patients would have actually wanted with respect to treatments and interventions. According to the CNA (2008a), when caring for patients who are no longer capable of articulating their wishes, nurses must support informed-decision making by respecting any previously stated wishes made by them. However, in circumstances laden with *uncertainty*, the participants were unsure what actions would have best respected the patient's wishes. Traditionally, moral distress has been defined as occurring when individuals are constrained from enacting their moral judgements (McCarthy & Deady, 2008). Though the participants struggled in making concise judgements regarding what would be morally right when *Working with Uncertainty*, they still described the experience as being morally distressing. To cope with this source of distress, the participants used proactive strategies within their practice. They would consult services such as social work and set up family meetings so that they could help engage the family in finding a resolution to the discourse between them. These strategies helped provide clarity amongst the family as to why there were differing opinions about what the patient's wishes were. They also offered an opportunity to

form discussions with families to help distinguish what clinical treatments their loved one would have wanted implemented.

4.3.2 Dealing with miscommunication.

Dealing with Miscommunication was a large source of moral distress for the participants. The participants described cases in which physicians would withhold pertinent information from patients and/or their families. The participants felt that when physicians would not openly discuss treatment trajectories or prognoses with patients and/or their families, they were doing them a disservice by withholding information. While the participants empathized with physicians and understood that they were not always able to predict patients' prognoses, they felt as though physicians could be more upfront when speaking with patients' families and providing them with all the information surrounding their care. For example, when describing working with physicians, Janice said:

I find all of our deceiving is withholding information. I know that they're trying to give them time like... family time to deal with it. But we can't save them from the grief they're going to feel and I just feel like we need to be more upfront in saying, 'They're not going to leave here [the ICU].'

Janice considered physicians to be the ones accountable to provide patients and their families with information regarding treatment plans. To further elaborate on her experiences in which she felt physicians would not openly communicate with patients and/or their families, Janice recalled a case in which she cared for a patient who had suffered a massive stroke. He had been in the hospital for two and half weeks and had not shown any signs of wakefulness. His family had notified the ICU team that his wishes were to pass away if he was left with any disability that would interfere with his ability to care for himself independently. In this instance, Janice felt as

though the physician team did not openly communicate with the patient's wife. The wife was not given regular updates regarding her husband's care. When a family meeting was finally held, the physicians told her, "*It doesn't look great. We're not thinking that he's going to have a great quality of life.*" Following the meeting, the team told Janice in private, "*Yeah, he's lucky to live a couple of more days.*" Janice expressed outrage and frustration that stemmed directly from the physicians not being clear with the patient's wife. When she asked the physicians why this information was withheld, they stated that they were hesitant to tell the patient's wife what they truly felt because it was based on clinical experience as opposed to a diagnostic test. Janice felt that the right thing to do was to openly communicate with the patient's wife about his prognosis. She was not in a position to tell the patient's wife this information because communicating prognoses was outside of her scope of practice.

In other situations where miscommunication caused the participants to experience moral distress, improper communication existed amongst different physician teams and patients' families. As previously discussed, patients admitted to the ICU often had multiple comorbidities; therefore, different physician teams could be involved within their care such as neurology, oncology, and nephrology, to name a few. When different physician teams were involved in a patient's care, they would not always relay messages appropriately or be open in terms of communication between themselves. For example, one physician team would tell the patient's family something about one specific aspect of the patient's illness without necessarily addressing their over-all health or the larger, holistic view. As a result, patients' families did not understand exactly what was occurring with their loved one's illness or they were given mixed messages by different physicians. As Julia explained:

There's definitely some communication problems going on there. A lot of the times I find the different teams... So there's like the intensive care unit, the ICU intensivist who will you know, 'We're looking at everything all together.' But then the oncologist will come by and say, 'Oh, white blood cell counts are okay today,' and they'll talk to the family and say, 'Everything is looking well on our end.' But then meanwhile from our end it's like well, you know, blood gases are terrible, their pressure is in their boots, they might not make it another 24 hours. But meanwhile another doctor told them that they're doing okay from another aspect. Sometimes it's hard for families and patients to grasp the whole picture or if they get hopeful then they sometimes just hold on to that. Often times we'll see like when a patient dies, after they'll be like, 'I don't get it, the other doctor said that they're doing better,' and it's like well, maybe in terms of that certain aspect of their health they weren't doing terrible but everything else... You know, they were multi-organ failure and they just couldn't fight it anymore. So yeah, a lot of times it can come as a surprise to patients and families.

In these situations, the participants did not believe that families were treated right and given all the correct information regarding their loved one's care. They could not rectify the situation as they could not communicate diagnoses themselves to patients' families as it was beyond their scope of practice. Their moral distress was also further intensified when the miscommunication created a false sense of hope amongst families as they believed that their loved one was improving but did not realize that it was only in relation to one aspect of their health.

Dealing with Miscommunication was a major source of feelings of helplessness amongst the participants. In situations like the ones presented above, the participants' beliefs that informed decision-making should be supported became compromised. They were able to recognize the correct message that needed to be relayed to patients' families, but it was

physicians who were in the position responsible for transmitting this communication appropriately. The participants coped with these types of situations by setting up family meetings to allow for an opportunity for physicians to clear up any miscommunication. Some of the participants also explicated that they dealt with these types of situations by avoiding thinking about the feelings (such as frustration and helplessness) that they elicited. Janice described, *“It just like weighs on you later on the day; like you try not to think about it”*.

4.3.3 Resonance.

Resonance referred to the situations that the participants felt related to their personal experiences outside of the ICU. As previously mentioned, the participants worked within close physical proximity to their patients as the nurse to patient ratio was usually 1:1. They were also assigned to the same patients for 12 hours a day, usually for two to four shifts in a row. Given their proximity and repeated encounters, the participants described that they would form therapeutic relationships with their patients and/or their families. However, certain cases involving patients and/or their families really stood out to them. These were the cases that resonated with them because the patient and/or their family reminded them of some aspect of their own lives. As a result, these cases were perceived as being particularly distressing. Even recalling these cases would continue to elicit emotions for the participants. For example, when describing these cases, some of the participants' eyes welled up.

In many of the interviews, the participants described that they had experienced moral distress from situations in which they strongly related to the patient and/or their family. As Diana described, cases that resonate *“...may remind you of a situation that you recently lived maybe in the last year with your own personal family.”* Caring for patients who were the same age as the

participants' children or that reminded them of their own family members particularly resonated with them. In relation to the nurses she worked with, Diana mentioned:

When you see the age groups and over the time, when the moms started having patients their kids' ages, that also had an impact. You could see the difference. Some people were like, 'That's my boy's age, my daughter's age' ...It brought it a bit closer to home. They made a link to make it personal...It just has more of a resonance with them; a connection that reminds you of some other stuff...Sometimes it can have a resonance just enough with you to make it more personal.

When participants felt a personal connection with patients and/or families that resonated with them, they were more apt to experience moral distress because they were more emotionally invested in their care. As Jen explained:

... when you identify with the patient that can be morally distressing because you're like, 'Shit'. You internalize it a little bit more. People the same age as your kids, that kind of stuff. That's the kind of shit I've seen nurses cry about.

Summer described a case that caused her moral distress that involved relating to a patient whose treatment decisions she disagreed with. She recalled:

*This man was like, I used to call him my tough little cowboy, and he had a below the knee amputation, he had a colostomy, he had severe diabetes. Like he had, like this was all before he came to ICU. **Before he came to ICU** [voice raised, emphasis added] he was a bit of a train wreck. So he comes to ICU and like again slow, slow rehab; slow, slow getting out. Got him to the floor, decompensated, came back down to the ICU and he was like, 'When do we put the breathing tube back in?' because he was still wanting to go on.*

In response to the situation, Summer stated, *“It was really sad because I had a very personal connection with this man...oh I cried.”* The personal connection to the patient was particularly evident as Summer described him as her *“tough little cowboy.”* Despite the nurse-patient bond, Summer found it difficult to respect and abide by the patient’s wishes. She could not comprehend why someone with such extensive illnesses would want life-sustaining interventions when it would only lead to poor outcomes. Even though she genuinely cared for him, it upset Summer to see this patient in a circumstance where he was unable accept the inevitability of his death.

Resonance significantly affected the acuity of the distress experienced by the participants. It caused them to internalize the situations that they faced and experience a greater intensity of moral distress than they felt from other sources. In turn, resonance affected the way that the participants coped as it was more difficult for them to deal with these types of situations. Part of the manner that they participants coped with distress was to create distinct boundaries between their personal and professional lives. Upon completing a morally challenging shift, the participants would try to leave their distress behind at work before going home. For example, Janice would unwind and cry in the car after a distressing shift before she headed home. Cases that resonated caused difficulty for the participants to cope as they found aspects of their professional lives would remind them of their personal lives.

4.3.4 Questioning the decisions of others.

Some of the most predominant sources of moral distress were situations in which the participants questioned the decisions of others. Since patients were most often in a position where they could not always vocalize their concerns in the ICU, it was usually left to other stakeholders such as patients’ families and physicians to make decisions related to treatments.

Summer articulated that when taking care of patients in the ICU, often times “*you’re doing all this stuff to them at the families’ or the doctors’ biddings.*” Conflicts arose from questioning whether these stakeholders’ decisions would lead to the right course of action. Moral distress would then occur for the participants when they would implement treatments for patients based on those decisions.

4.3.4.1 Decisions of patients’ families.

Disagreeing with the decisions that patients’ family members made regarding care appeared to be one of the most significant sources of moral distress for the participants. The participants shared many examples (presented below) where they questioned patients’ family members’ decisions when they would request treatments that seemed futile and/or went against a patient’s previously stated wishes. The participants recognized that these decisions could be influenced by families’ different spiritual, cultural, and religious beliefs. Families’ lack of knowledge about the ICU and the interventions it could offer also impacted these decisions.

When the participants questioned the decisions of patients’ families in relation to treatments that were perceived to be futile by healthcare professionals, they used bold language that revealed how they felt. In particular, when patients appeared to be approaching an imminent death and families would continue to ask for life-sustaining treatments to be initiated or continued, the participants would make comments such as “*they were pushing*” or “*they made us treat.*” One such example that detailed the experience of questioning a family’s decisions was provided by Jen who had cared for a 92 year old patient with multiple comorbidities whose lungs were “*not recovering.*” He was unable to vocalize what his wishes were and had no previous advanced directives. When speaking about the family, she said:

They made us intubate him, they made codes [performing advanced cardiovascular life support], his ribs were broken. They made us put in a feeding tube [participant sighs]... Even the language I use you can see that I don't agree with it, eh? Yeah, so they just insisted that everything be done and we all, myself and much of the nursing staff and physicians, felt that these measures were futile and we did respectfully give our opinions and the information that these measures were not going to bring him back and in the long-run were likely to prolong suffering. But the family was very clear that they just wanted everything done.

In examples like the one presented above, the participants were not simply bystanders who watched as the situation unfolded. They enacted moral agency by attempting to maintain what they believed was right. They spoke with patients' families to let them know what these interventions entailed and how they could potentially cause pain. If families still insisted on continuing these treatments despite being informed of what they entailed, the participants felt as though they were then 'forced' to perform them. While they had no knowledge of what the patients' actual wishes were, they believed that no one would purposely want interventions that would cause such suffering. Despite their efforts, they were unable to uphold the ethical nursing obligations of supporting a dignified death and alleviating and preventing patient suffering.

In contrast to the example presented above, the participants also recalled situations where they experienced moral distress because they knew their patients' wishes were to not have any invasive treatments yet their families would disregard them. These wishes were known because the patients had articulated them to the ICU team earlier in the admission when they were able to do so. In these cases, when the patients had deteriorated to a point where life-sustaining treatments would be required, their families would decide to pursue treatments that were inconsistent with the patient's previously stated wishes. Situations like these were distressing for

the participants because as Jen explained, *“When you know that what you’re doing is against someone’s wishes, that’s hard because their families often override their decisions and there’s not really much you can do about it.”* Diana provided an example in which she experienced moral distress when a patient had articulated wishes to the ICU team that were then disregarded by the family. This patient’s wishes were to turn to palliative treatments if their ailments did not resolve. Instead, the family decided to push for further invasive treatments and refused to have any analgesics administered to the patient, thereby preventing Diana from assisting the patient in achieving a dignified death. When speaking of the patient’s family, she said:

...they were pushing...they wanted everything done. They didn’t want their loved one to have pain medication. Despite the fact that they didn’t understand, they thought it would make it worse. So that to me was almost inhumane, and at one point they were following those. We needed to follow those guidelines because that’s what the requests were. Despite the fact of multiple talks with the family to say, “... can’t do this, the futility of the treatment” ...To me a dignified death was to promote comfort and the understanding of what the patient wanted, which was their wish at the beginning. Their wish at the beginning was to be comfort care down the road if some stuff wasn’t going to resolve.

The moral distress that Diana experienced became evident as she expressed how *“inhumane”* she believed the decisions of the patient’s family were. Even when advocating for the patient’s wishes (to institute palliative treatments if their ailments did not resolve) by bringing them forth in family meetings, the family continued to make decisions that were inconsistent with them. Diana was then placed in a position where she told herself, *“You need to accept this because that’s the reality. You’re not going to change it.”* To cope in situations like these, the participants tried to the best of their ability to speak with families and reiterate the importance of respecting

their loved one's wishes. However, when despite their strongest efforts families were adamant of continuing these interventions, the participants had no choice but to accept the situation as it was. They had to engage in self-care (by accessing support) to help them overcome their distress and channel their inner strength to reach closure with the situation.

Jen also had a morally distressing experience that was similar to Diana's. Jen's example slightly differed because the patient's family had differing opinions of what treatments should have been implemented. The patient was quickly deteriorating and all of the family was in agreement to withdraw life-sustaining therapies. However, one family member was in disagreement and then convinced the rest of the family to continue the therapies. Jen explained the case as follows:

*We had another guy who was...he had a lot of complications after a cardiac surgery. It was supposed to be a minor cardiac surgery but the reason he had it was because he was having a bit of shortness of breath going up and down the stairs and that interruption in his quality of life was too great for him to the point that he was willing to do this surgery to try to correct it because that was unacceptable to him. To have **that** [emphasis added] imposition on his quality of life. So do you think that he would want to live out of it and hooked up to a ventilator and everything? And everyone in the family was in agreement except for one sister who pushed and was waiting for a miracle and made...guilted the rest of the family into continuing. It took him three months to die in our ICU, a horrible death.*

The decision of the one family member to wait for a miracle heavily influenced the goals of care for this patient. Though the rest of the family initially believed that the patient would not have wanted life-sustaining therapies, they became convinced by the one family member that the right thing to do was to continue them. When the goals of care were changed by the family, Jen

experienced moral distress as she believed the patient's wishes were not respected. She could not uphold the ethical nursing obligations of supporting patient decision-making.

4.3.4.2 Decisions of physicians.

In contrast to the aforementioned examples involving patients' family members, the participants also described morally distressing situations in which they questioned the decisions of physicians regarding patient care. The participants worked with different teams of physicians who would go through many staffing turnovers. They felt that each physician would influence the patient's care in accordance with his/her own opinions. Some would focus on the end goal of the patient, whereas others would move forward with a focus on treating rather than looking at the "big picture". When working with different physicians, Christine explained, "*It's like going to a different hair dresser, they have a different opinion of things. And it's not to a fault but sometimes there can be a bit of a difference in thought. Every physician has a different school of thought.*" There were therefore certain times in which the participants' beliefs of what was right contrasted with the physicians' decisions. The two main situations in which participants questioned physicians' decisions were related to when physicians neglected patient's wishes and when they did not provide patients with what the participants perceived to be appropriate treatments.

A common situation that caused the participants moral distress within their practices was when physicians neglected patient's wishes; specifically, when they would convince patients or their families to rescind their "do-not-resuscitate" orders and opt for full treatment (including CPR) instead. Summer explained:

We'll have someone on the floor who's a category three [do-not-resuscitate] and all of a sudden they're decompensating and doing poorly and the surgeon or the doctor or whatever

somehow convinces the patient or the family at three in the morning that you don't want to be a category three anymore, you want to be a category one [full ICU treatment including CPR]. You want to go to ICU, and that's just not appropriate.

In cases like the one presented above, Summer expressed that there was great difficulty in understanding the rationale behind why physicians would want to neglect patients' wishes. Moral distress would result as the participants were unable to support the nursing ethical obligation of upholding patients' wishes.

Another example that entailed questioning the decisions of physicians was told by Janice who cared for a patient that she believed the ICU team had failed. The case involved an admitted ICU patient who was awaiting a liver transplant that Janice felt was not treated as diligently as possible by the physicians. She described the case as follows:

They were an alcoholic and they had all these esophageal varices and this person was sat on...It was always like, "Oh, a low hemoglobin, she's still waiting for transplant". "A low hemoglobin that trickles lower every day. When it hits 80 we'll transfuse her." "When it hits 70 we'll transfuse her." "Eh, well she's fine until she's in the 60s". And then all of a sudden she's in the 60s all the time and no one's really looking into why she's bleeding. So of course she arrests and we find all of these varices because we blow them up during CPR and she bleeds out. ...We were pissed off about that because we'd just been sitting on this person because they were able to talk to us and they were able to move and not doing all the super acute things...In the end we still had to do three rounds of CPR. The whole room was covered in blood, she was covered in blood, her pupils were blown. And then the family has to go in and see that and we see the family breakdown. And we're just like we failed on so many different parts. We failed to treat

quickly, we failed to even prolong, like keep her healthy enough to get her to a transplant, we didn't do that either.

Within this example, Janice questioned why the physicians made decisions to not treat or attempt to discover the source of the low hemoglobin. She brought up the low hemoglobin to the physician team but was told that they were aware of it and that no interventions were required. Moral distress manifested itself as Janice believed that the way the patient was treated was not right. These feelings of moral distress were then intensified by seeing the family's reaction to the patient's death. The family's breakdown further prompted Janice in thinking that the whole ICU team had failed the patient. She had been unable to uphold the ethical nursing obligation of promoting the health and well-being of the patient.

4.3.5 Prolonging care.

A relatively common source of moral distress for the participants was situations in which they prolonged the care of patients who were dying. Working in the ICU exposed the participants to caring for critically ill patients who would often not recover from their illnesses. When they cared for patients with significant life-limiting diseases, they perceived life-sustaining therapies as being aggressive, causing undue suffering and prolonging an inevitable death. The participants felt that when death was prolonged, they were acting against their ethical nursing obligations which valued the well-being and comfort of patients. Jen explained:

So your number one goal, like I mean you want to save and you want to help, but you want to prevent suffering, right? ...You want to help and not harm but a lot of the things we do it's hard to see the benefit of and they're painful.

When the participants spoke of situations in which they prolonged the lives of patients who were dying, they felt that the treatments they implemented were “aggressive” in nature.

When asked what “*aggressive*” treatments encompassed, the participants responded that they were commonly invasive treatments such as intubation, surgery and CPR; however, they were not limited to just these therapies. The day to day interventions that the participants performed were also perceived to cause significant discomfort to patients. These included deep suctioning via tracheostomies, turning patients whose blood pressure would decrease as soon as they were on their side, changing “*dressings on people whose bodies are just rotting*”, and putting in nasogastric feeding tubes (to name a few). Performing these daily procedures exposed the participants to “*see people who are just in so much agony.*” Even when patients were sedated and could not vocalize the pain that they experienced with these interventions, non-verbal cues such as furrowing their brows or grimacing were evident. When explaining what these “*aggressive*” treatments entailed, Jen said:

So there’s a lot of different things but like so CPR is one of the most obvious, like the whole jumping up and down on the chest of a 92 year old, but that’s only a small part of it. It’s the day to day stuff. ...It’s the feeding tubes and the trachs and the ET [endotracheal] tube. It’s just all of these horribly unpleasant things that are meant to bridge a gap for someone who may return to what we usually consider an acceptable quality of life, but for a lot of people that’s just not going to happen.

When performing these interventions on patients, the participants viewed them from the perspective of outcomes. When they were performed on patients who were expected to have good outcomes and able to reach a quality of life that was acceptable for them, the participants did not consider themselves to feel morally distressed. However, when they were performed on patients that would never improve, the participants felt as though they were prolonging an

inevitable death. Christine summarized the experience of providing “aggressive” treatments as follows:

It's like a patient who has gone through a traumatic surgery and they're 90 years old and you've done CPR, you've cracked ribs, you've brought them back...but the outcome is what I'm getting at; like it's less distressing if they're hopefully going to have a good outcome but if you know it's going to be sort of months or weeks and weeks of this, then it is distressing.

When providing “aggressive” treatments, it was less distressing for the nurses if they knew that these treatments were what the patient would have wanted. For example, Julia explained, “*If they were willing to give it that chance, if they were like, 'I'm willing to die like this in order to give myself a chance', then that's less distressing than someone who is like, 'I would never want to be on the ventilator.'*”

The examples that were provided by the participants consisted of situations in which they were providing a multitude of invasive treatments but could not alter the fact that the patient's health could not be restored. Their distress stemmed from their belief that they were causing unnecessary suffering for the patient. Julia provided an elaborate example in which she cared for a patient whose care was being prolonged. She recalled:

He was really, really sick...Basically every single organ was failing and every day, everything was getting worse. His blood work was getting worse...He was on all of our support. He was on every pressor we could offer, he was on epinephrine, he was on SLED [sustained low-efficiency dialysis]. We were just doing everything possible and he just kept getting worse and worse...He was going to die no matter what... We couldn't turn him because he would tank his pressure. He was so swollen like it was just, it was painful to watch...Anytime he would open his eyes he would look like a deer in the headlights. You would try to calm him down and tell him

where he is, “everything is okay, this is happening”. But you can just sometimes see it, how scared they are in their eyes.

Within Julia’s example, she was able to capture the many interventions that she was performing that she believed were causing the patient to suffer. She felt that the patient was still going to die despite all of the life-sustaining interventions that were implemented. Her professional obligation to alleviate suffering and support a dignified death was compromised.

4.4 Theme 3: “It Just Felt Awful”

Moral distress for the participants was characterized by a variety of negative symptoms that affected their biopsychosocial health which were captured in three subthemes: *Emotional Characteristics*, *Physical Characteristics*, and *Psychosocial Characteristics*. The *Emotional Characteristics* consisted of the impacts of moral distress on participants’ emotional health. The *Physical Characteristics* included the physical symptoms that the participants exhibited when they would encounter moral distress. Lastly, the *Psychosocial Characteristics* was comprised of the impacts of moral distress on the participants’ psychological and social well-being. These negative symptoms prompted the coping process for the participants so that they could manage and deal with them.

4.4.1 Emotional characteristics.

Moral distress was associated with effects on one’s emotional health for all the participants. Even recalling the situations that caused them moral distress would elicit emotions such as becoming tearful during the interviews. They were also noticeably frustrated when they spoke of how they felt when they could not alter the situations they encountered. This frustration was made visible as the participants made notions such as clenching their fists and furrowing their brows. Though moral distress had many negative emotional impacts for the participants,

they most frequently described feeling “*awful*”, “*uncomfortable*”, and “*frustrated*.” Other emotional impacts of moral distress included feeling “*angry*”, “*stressed*”, “*tortured*”, “*horrible*”, “*sad*”, “*helpless*”, “*anxious*”, “*uneasy*”, “*horrified*”, “*hopeless*”, “*annoyed*”, and “*traumatized*”. When Valerie described a morally distressing case, she noted, “*I just felt so horrible inside, I don’t know how else to describe it, it’s just like tortured up inside.*” Jen explained the consequences of moral distress as “*It just hurts in your heart a little bit.*” Two of the participants also reported that certain situations impacted them to the point that they would cry at work or on the way home.

The language that the participants used to describe morally distressing situations was also quite bold. These cases were described as being “*brutal*”, “*horrific*”, “*disturbing*”, “*horrendous*”, “*inhumane*”, and “*traumatic*”. The following quotations were used to describe how the participants felt about some of the morally distressing situations they had encountered:

“*Worst code ever, everything was horrendous...*” – Janice.

“*I’m going to use the word ‘haunting’ which is a bit heavy but that’s something you don’t un-see*” – Jen.

“*It was painful to watch*” – Julia.

“*It festers inside of you*” – Summer.

When faced with moral distress, the participants noted that they also felt “*powerless*”. In all of the morally distressing situations, whether it was due to prolonging care, miscommunication, or questioning the decisions of others, the participants felt that they knew what the right course of action was. However, they were unable to alter the course of events to achieve what they believed was right. Instead, they felt “*forced*” to comply and to continue performing actions that they disagreed with. Julia explained that in response to a situation in

which the patient's family was pushing to prolong a patient's care with life-sustaining treatments, she felt as though she was unable to help the patient. She explained, *"Like I wanted to do more for him, give him more sedation, give him, just like help him. But there's only so much you can do."* Jen also explained that in situations when families wanted certain treatments implemented that she believed may be futile, she was unable to alter the situation or change the outcomes for patients. These feelings of powerlessness then contributed to her experience of moral distress. She described, *"There's definitely a great sense of powerlessness that I think contributes to those feelings. You can't really, you can't do anything about it."*

When the participants spoke of how they felt in response to moral distress, the emotion of empathy was also mentioned. They exhibited empathy for both patients and their families. For patients, empathy arose from seeing them in positions where the participants perceived that they were suffering. By caring for them in these circumstances, the participants empathized with their discomfort. Julia described empathizing with a ventilated patient whose care was being prolonged as: *"Like I could feel it in myself. Like the empathy is just like, I imagine myself in his position like probably like scared, confused. And just imagining basically being in that bed on the ventilator."* At other times, the participants empathized with families whose loved ones were in the ICU. The participants commonly experienced moral distress from questioning the decisions of patients' family members in regards to treatment plans. However, they explained that they also empathized with patients' families and recognized that they were faced with difficult choices when deciding upon treatment options for their loved one. Jen explained that when families made treatment decisions, they were not based on negative intentions. They made them because they cared for the patient. However, the families did not understand what the ramifications of their decisions would entail (such as prolonging patient suffering). She

explained about patient's families: *"I don't think people are trying to be mean, I think they just don't get it."* These families simply did not have a comprehensive understanding of what their decision-making would result in for the patients.

4.4.2 Physical characteristics.

The participants also described the physical symptoms of moral distress that they experienced. These *Physical Characteristics* included all of the associated impacts that moral distress had on their physical health. Of the seven participants, four had previously experienced negative physical symptoms from moral distress. The most common was trouble sleeping. The participants also reported that they would have nightmares. Christine stated, *"I kind of have a lot of nightmares about work too but then again it is a highly stressful environment."* Other physical symptoms included having an upset stomach, feeling sick inside and being physically exhausted. Julia explained that when she encountered a situation that caused her moral distress, she would feel physically ill. She said:

...after that exact case, I actually got sick right after it. I remember going home that third night being like so exhausted. You know, that combination of physical and mental exhaustion, and I remember that next day I woke up and had like a sore throat and wasn't feeling good and I felt like, I just felt worse and worse for a few days.

Summer even reported that moral distress would result in physical symptoms in which she had to cancel coming into work. She would develop an upset stomach and dread returning to work. She stated:

I often get like an upset stomach about work and you know, just that whole dreading going to work. I don't want to go and feeling like, feeling ill. So I know if I've gone through a particularly bad stretch, it won't take much for me to call in sick.

4.4.3 Psychosocial characteristics.

The third subtheme, *Psychosocial Characteristics*, encompassed how moral distress impacted the participants' psychological and social well-being. For the social characteristics, two of the participants noted that after encountering a particularly morally distressing situation, they would withdraw from their own family and friends. They were also less inclined to participate in social situations. Julia described the social consequences of moral distress as the following:

...sometimes I'll come home after a shift and I'll have plans to go to a birthday party or whatever and sometimes you just can't do it. Sometimes I can go out after and just like socialize. But sometimes it just everything just seems, I don't know, not important anymore. It's just like after experiencing something like that, it's just like...don't want to do it. You just don't feel like being social or you know, caring about anyone.

Psychologically, the participants described how repeated exposure to moral distress began altering their professional self-image. They noted that when starting their careers, they viewed nursing as a profession that was linked to helping patients. However, after repeated exposure to moral distress in the ICU, some of the participants began believing that they were not always helping patients. Instead, they believed they were contributing to patients' pain and suffering due to factors outside of their control. Janice stated:

Whenever you ask pretty much anyone who ever went into nursing why they went into nursing: 'Oh, I want to help people' ...You're doing the opposite of what you thought you were going to make people feel. Like you're not making people feel comfortable, you're causing them distress from something you can't control.

One participant even noted that she perceived herself as being a "torturer" in the ICU who harmed patients with the treatments that were implemented. She explained:

No one wants to feel like what you're doing is wrong and that you're hurting people. We went into nursing to help people. We went into nursing because we want to make things better and here we are causing people pain and distress. And studies have shown patients have like PTSD from being in the ICU because it's such a torturous experience and I'm like that's me...I'm the torturer.

Participants also reported enjoying their position in the ICU less because of moral distress. Three of the participants expressed feeling that they wanted to work less hours or leave their position entirely. Summer mentioned that she thought of changing professions. She said, *"I think I've only got so long in me because I can't deal with this anymore...Sometimes I think I'm going to leave nursing entirely."*

While moral distress impacted the participants' professional self-image, they all felt that they never treated patients or their families differently because of it. They would continue to provide patients with quality nursing care even if they disagreed with the treatment plan. Diana, a nurse with over 35 years of experience, did however note that over time, she noticed some of her colleagues becoming defensive when caring for patients. They changed their approach in caring for them. She explained further, *"...they had changed their approach...They're more guarded."* When nurses became guarded, they were less *"trusting"* of patients' families. Being defensive and guarded was a way that nurses protected themselves from experiencing moral distress.

4.5 Theme 4: "Dealing with It"

The final theme, *Dealing with It*, depicted how the participants coped with moral distress. Each participant shared their perception of what coping meant to them and they all associated the concept of coping with having to *"deal with it."* They defined it as a method to *'deal'* with

unpleasant and stressful events. When expanding upon what it meant to ‘deal’ with something, Valerie described it as “*what actions you take to make yourself feel better in like a stressful situation or an unusual or unpleasant situation.*” Coping was also viewed as a method to handle one’s “*emotions and thought process*” after an event occurred. Of all the participants, Diana’s definition of coping differed. She believed coping meant she had to “*deal with it and move on. Don’t go and delve any deeper. Just move on.*” All of the participants in the study mentioned that they believed that coping was subjective and unique to each individual. Julia explained, “*Everybody’s coping methods are different. So whether it’s something you do to deal with something head on or distract you. Basically whatever you do to get through whatever it is that you need to get through.*” Since coping was subjective, the participants noted that what may be a useful coping strategy for one individual may not be effective for another. Lastly, coping was viewed as a process. It entailed engaging in self-reflection to become knowledgeable of one’s strengths and weaknesses. By doing so, one’s coping strategies would change over time as methods that were once useful could become ineffective, causing one to re-evaluate their strategies.

Once the participants had described what coping meant to them, their specific coping strategies were then explicated. These strategies were separated into four subthemes: *Having an Outlet*, *Avoiding It*, *Connecting with Someone Who Gets It*, and *Getting Yourself Back Up*. *Having an Outlet* reflected the strategies used by the participants to release the emotions and stress they experienced as a consequence of moral distress. *Avoiding It* referred to the coping strategies in which participants avoided the morally distressing issue at hand. *Connecting with Someone Who Gets It* represented a strategy in which the participants sought and connected with

others for support. *Getting Yourself Back Up* depicted the coping strategy in which the participants came to closure with the morally distressing situation and moved on from it.

4.5.1 Having an outlet.

Having an Outlet reflected the strategies used by the participants to release the emotions and stress that they experienced. Each participant expressed that they had their own unique outlet, with the most common being physical activity. They would engage in activities such as hiking, running, yoga, and general exercise. Other outlets included gardening, drinking wine, writing in a journal, reading nurses' blogs, going out with friends/family, and joking/laughing with colleagues. Julia would read blogs and books written by nurses as their experiences would validate that she was not alone in experiencing what she felt. She said, "*Reading other people's experiences too helps. Like reading nurses' blogs or books. Basically first person accounts...Nice to know you're not alone, people experience it as well.*" Two of the participants explained that their outlet was to "*unwind*" before going home after encountering a morally distressing situation at work. At the end of their shift, they would spend some time in their car before leaving to go home. Christine explained:

If I've had a really bad day at work or a stressful, distressing day, I know myself. I know the mood that I'm in and I'll let myself cope almost in the car. Like I won't go inside... Like today was stressful, listen to music and then go and shower and that's it.

Comparatively, after a distressing shift, Janice would unwind in the car by crying. She explained, "*I'll like get in the car and immediately be like, 'Worst code ever. Everything was horrendous. The family was so bad. I want to cry all day.' Just let me cry for the next 20 minutes.*"

These outlets were perceived as more of a distraction than a solution. Jen explained, "*I do things like go to the gym, try to distract yourself. Try to remove yourself somewhat.*"

Christine also used these outlets as a way to forget about what was causing her moral distress. She would bring a book with her to work to help distract herself on break during particularly stressful shifts. She stated:

I think it's honestly just to escape it all. Typically I'll bring a book or my phone and I distract myself. I like to go somewhere quiet...I'll give myself a minute or two to be like, 'Okay, this is a stressful day or this is distressing.' But then I'll distract myself.

When asked whether these outlets were helpful, a few of the participants were unsure. Summer would engage in physical activity to help her cope, but questioned its effectiveness. She said, *"I do yoga or like exercise, which I hate. I do, it's awful. So I'm trying all these things to help me cope but I don't know if they're helping or not. But like I said, I try."* A reason why these "outlets" would have questionable efficacy in helping is that they did not assist the participants in addressing the issue at hand. They were more temporary distraction, which could be effective for the short-term, but not necessarily over years. In relation to using "outlets," Diana exclaimed, *"I'm not sure it's addressing the issue. Maybe for that week, but I don't know if you want to keep up with that."* These outlets did however temporarily help the participants release their emotions so that they could return to work after a distressing shift. Conversely, to be able to cope with moral distress across the span of a longer time period, the participants required other coping strategies.

4.5.2 Avoiding it.

The subtheme *Avoiding It* referred to avoiding the morally distressing issue at hand. Participants would either avoid thinking about the issue or remove themselves entirely from it. Not thinking about the issue was a common tactic. At times the participants would be so busy with other tasks at work that they did not have time to think about the issue. Christine explained:

Sometimes it's so busy that you don't have time to cope with it. I guess that might be a way of coping by doing what you have to do, right? Well I feel distressed by this but I have to change my IV [intravenous] tubing, I got to bathe them, change them, they're unstable. It's not a great coping mechanism but it's letting your mind rest.

At the other times, the participants would purposely distract themselves by thinking about other things. They would also simply try to ignore the issue. Summer provided an example of doing so as she stated, *"I think I'm an avoider... Like I don't think we deal with it, we just kind of shove it down and ignore it."*

In contrast to not thinking about the issue, some reported that they would avoid morally distressing situations by removing themselves from the causative source. It is important to note that no participant ever left a situation in which the family or patient was in need of them. Instead, they would remove themselves when it was safe to do so (i.e. the patient was not in a critical condition and another colleague was able to cover them). When the participants avoided a specific situation, they would usually leave the unit and go for walks or to a coffee shop. Christine explained that when she would encounter a particularly morally distressing situation, she felt as follows: *"Like I need to go and get a coffee and getting off the unit, getting away from everyone, going outside. Those sorts of things really help."* Though the participants would temporarily remove themselves from sources of moral distress, none of them ever reported changing patient assignments because of it. They were aware that they did have the option of asking the management staff for a change of patient assignment. However, the participants felt as though they were backing down or would be judged if they refused to care for a patient. Janice explained the following when she felt morally distressed but did not want her assignment altered:

They offered to switch my assignment. But again, I felt like I would be a wuss if I didn't go back. And I felt like then that patient's family thinks that they call the shots and that's not good either, so I should just go back and deal with it again.

Lastly, another method used to avoid situations that caused moral distress was to call in sick. Summer noted that on certain days, she could not “*fake going to work*” because of her moral distress. When faced with a “*rough*” event, Summer felt as though she was not able to return to work the next day and pretend as though she was not still impacted by the situation. She explained, “*So I know if I've gone through a particularly bad stretch, it won't take much for me to call in sick.*” She also described that she was quite unsupported at work if she did not “*fake*” it and instead showed her true feelings. Her patient assignment would remain unchanged and there was no acknowledgement of how she felt. She stated, “*There's no consideration for your feelings in the ICU. So if you say like, 'Oh I can't' or if you've had a particularly bad day, they won't give the easy assignment the next day. Like there's none of that.*” Given the lack of support Summer experienced, calling in sick was a coping strategy she utilized.

While *Avoiding It* was a common tactic the participants used to cope with moral distress, they did affirm that it was not always effective for them. When asked if avoiding the issue was helpful, Summer replied, “*It does, but it doesn't mean it goes away. It's still there in the back but it's how I get through every day. It's not thinking about the stuff.*” For Summer, it appeared to be necessary for her to avoid thinking about what caused her moral distress so that she could proceed through her day at work. Diana noted that when ‘*Avoiding It*’, “*I think for a certain time it's not a bad thing, it's probably good, but if it becomes a routine thing, I'm not sure how good that can be. So that's why I say it always catches up to you.*” This coping strategy was not sustainable or always effective in helping nurses address their moral distress.

4.5.3 Connecting with someone who gets it.

Connecting with Someone Who Gets It represented a coping strategy in which the participants sought and connected with others for support when experiencing moral distress. Connecting with others was important as nursing was described as a profession that required team work. There was an important aspect of socialization within the participants' practices. The participants described the importance of seeking '*someone who gets it*' when looking for support, meaning an individual who was able to understand the morally distressing situation without making any judgements. These individuals who "*got it*" were predominantly other nurse colleagues who were also employed within critical care. When the participants explained how they would connect with someone who "*gets it*", the importance of trust, mentors and having a safe haven was emphasized

4.5.3.1 Trusting others.

When *Connecting with Someone Who Gets It*, the participants would seek individuals who they were able to trust and who understood the context of the morally distressing situation that they experienced. The individuals that the participants would seek out were predominantly other ICU nurse colleagues, educators or charge nurses since they would be able to discuss distressing situations amongst one another with ease. They understood what it was like being an ICU nurse and having to face these difficult situations. They would be able to reaffirm what was going on and offer suggestions regarding what actions could be taken. Often times they had also cared for the patient whose care was the root of the participant's moral distress or they had experienced a similar situation in the past. As a result, the participants did not have to describe every minute detail of the situation or explain any of the medical terminology or treatments. Diana explained that when speaking to other nurses who "get it", "*they don't have to give the*

context. They don't have to explain. They're not going to be judged, it's like we get it." Summer added on, *"...they understand and they've been there and they know what I'm talking about. I don't have to explain every other word."*

When deciding upon whom to seek for support, the participants would connect with those they believed were trustworthy whom they could confide in. When asked whom she would connect with, Christine answered:

People that I can trust. People that I aspire to be like a little bit. Like she has all the qualities of a good nurse and she's empathetic and seems to understand what the right thing to do is most of the time or she's been through it.

Other colleagues that the participants trusted and would connect with included priests and spiritual care workers. They were viewed as individuals who were *"understanding"* and would be able to see the *"big picture aspect"* of what was going on. They were able to help the participants in examining the morally distressing situation from a different view by incorporating the perspectives of patients, families and physicians. Lastly, the participants would occasionally speak to their friends and family about the situations that they would encounter, but felt that they did not fully grasp what was distressing about the explained case. Therefore, most of the participants would not discuss their work outside of the unit. Christine explained that her friends could not relate to her experiences from the ICU so it was difficult to talk to them about it. She stated:

I think of in my life I don't really talk about work outside of my work to be honest... it's just not relatable to a lot of people for me to even get into. Like a lot of my friends didn't even know what the word intubated meant and it's too much work to get into telling people about it and I'm like honestly, they probably don't even care.

Being unable to talk about work situations to friends and family can be isolating. Julia also had a difficult time explaining the complexity of her ICU experiences to her friends and questioned whether others outside of work should even know what the reality of her practice was. For example, she felt she could not tell her friends and family about situations in which treatments were being implemented that were inconsistent with patients' wishes. She explained, "*...sometimes you don't want to tell them the things that happen in the intensive care unit. It's like...that was really fucked up. Like people shouldn't.... know.*" Julia felt that these situations should only be discussed amongst individuals (i.e. ICU nurses) who could understand the complexity of them. The reality of her practice was that unspeakable situations occurred in the ICU. As a result, she felt as though she had to protect her friends and family from knowing what the context of the ICU was really like.

4.5.3.2 Mentorship.

Though trust was a prominent feature when seeking others to connect with, the importance of *Mentorship* also arose. The participants with less experience (i.e. less than seven years of nursing experience) explained how they looked up to more senior nurses when it came to coping with their moral distress. They would seek them and ask them for guidance and advice when they were faced with difficult situations. These participants often questioned how senior nurses could be doing the same ICU job for so many years but perceived it as a sign that perhaps they would be able to do so as well. For example, Christine recalled a shift that was particularly distressing for her when she first began her career in the ICU where she was buddied with a more experienced preceptor. When her shift ended, she spoke to her preceptor and recalled saying, "*I don't know if I can work here.*" In response, Christine explained that she and her preceptor "*... just talked about it and she told me that she felt the same and hearing that my preceptor who is*

training me felt the same way as me and felt distressed made me feel like this is normal.” By becoming aware that senior nurses still felt morally distressed, the less experienced participants’ emotions were validated. Seeing more experienced nurses being able to cope with moral distress also inspired the participants that they too would learn how to overcome their distress. Janice explained:

Seeing other nurses who have been there longer who deal with horrible code after horrible code and being able to close the door makes me think, “Okay, if they can do it then this is something I’m going to have to be able to do.”

The nurses that Janice described were also still morally engaged in their practice. She perceived that these nurses continued to provide their patients with optimal nursing care despite the distressing events that they had encountered throughout their careers.

While the less experienced participants sought out nurse mentors, Diana, a participant with many years of nursing experience, explained how she was a mentor to a lot of the ICU staff. Given her vast experience, she had seen many colleagues experience moral distress, some of which consequently left their positions in the ICU. She believed that it was of utmost importance to connect with others for support within the ICU as the effects of moral distress could be detrimental on individuals who would keep their emotions hidden inside. She believed that the effects of moral distress would accumulate and eventually become something *“bigger than what it is.”* When new staff were hired within the ICU, Diana would tell them in regards to moral distress:

Don’t keep it in... It means talk to somebody around. So that means you can talk in between yourselves, you can talk to your mentor, you can come to talk to me anytime. You need to talk. You need to express it.

By explaining the importance of talking to others about how one feels, Diana felt that it got “*the discussion going*” and “*demystified*” the feeling of moral distress. As a source of support for other nurses, Diana always made herself available to listen to others and offered them advice such as seeking extra help when she believed that their moral distress was strongly affecting them. She explained, “*At one point I know they need to do the next step. There’s the listening part but then it’s like it’s beyond me. It’s beyond anything around here sometimes and they need to get extra help.*” Extra help referred to seeking professional support from a source such as a counsellor.

4.5.3.3 *Having a safe haven.*

When connecting with others, it was also important for the participants to have a safe place in which they could do so. The *safe haven* represented the physical space that the participants would use to speak to others when they needed support. The most common *safe haven* was reported by the participants to be the break room, though others preferred to leave the unit to speak to colleagues in private. The participants explained that the break room was viewed as a safe place to discuss morally distressing situations because “*it’s far away from all of our beds [inpatient beds] and it has a door that closes and locks.*” When discussing cases in the break room, groups of nurses would gather to describe a distressing case and examine and question the decisions of the physicians and the patient’s family. Some of the participants found the break room helpful as they were able to “*vent*” about what was causing them distress and release the emotions they were experiencing. They would also be able to hear the perspectives of others nurses who would examine the situation from a different angle. These nurses would look at the situation from the perspectives of all the individuals involved in it (such as patients, families and physicians). By doing so, they were able to shed some light on factors that might

not have been originally considered by the participants. They would also help offer some advice as to what actions the participants could take to help rectify the situation. Comparatively, other participants found the break room to be a “poisonous”, “toxic” environment that involved a lot of “ranting” and criticism of the decisions of patients’ families. Christine explained:

Sometimes the break room can be even more anxiety provoking. Not always, but you have certain people who will talk about patients on break and talk about these things and it’s not always unpleasant at the time but then you think, you go back and think, ‘I didn’t really have a break, we just talked about patients during my lunch hour.’

Given that the break room could be anxiety-provoking, the participants mentioned that they would leave the unit at times to speak with colleagues. For example, Janice said that she would often ask close colleagues to join her for a walk outside of the unit. By doing so, she also did not have to reveal how she felt in a large group setting such as the break room.

4.5.4 Getting yourself back up.

The final subtheme, *Getting Yourself Back Up*, depicted the coping strategy in which the participants would reach closure and move forward from a morally distressing situation. Closure was the point in which the participants came to terms with their morally distressing experience. When the participants encountered morally distressing situations, they were not simply bystanders who watched as they unfolded. The participants enacted moral agency by making numerous efforts to alter these situations to achieve what they perceived was right. They would advocate for what they believed was right, have discussions with physicians and families to reiterate their moral concerns, initiate family meetings, consult services such as social work, make suggestions on interprofessional rounds on how patient care could be ameliorated, articulate their concerns to nursing management, and approach experienced nurses for advice.

When despite these efforts they could not alter the situation, the participants would not let their emotions and distress overcome them. Instead, they were able to get themselves “back up”.

Diana explained *Getting Yourself Back Up* by referring to an analogy using zebra grass. She described how this grass would continue to stand despite strong winds that would blow it down. She stated:

I have a lot of grass in my garden and it's the 12 feet zebra grass. Sometimes we have big winds. When it brings it flat to the ground, and then it just goes up, goes up the other way...But you know what, when I look at it, even if you fell, it's how fast you get up. You see that's what happened with the grass. It doesn't stay there. It just moves up again. Yes, you'll fall. You'll have experiences that will bring you moral distress but then it's like how do you get back there?

Just like the grass, the participants' roots were firmly planted and they were able to withstand adversity. They were assertive and stood strong in the wind. They were confident in what their role entailed and what their professional ethical obligations were. When the wind blew and they fell to the ground, the participants acknowledged their personal limitations in response to the situation. However, they did not normalize or become complacent with these morally distressing situations. Instead, they were engaged in a continual process of learning how to apply their skills, experience, and knowledge to work with and through moral distress. They also recognized when they needed to engage in self-care and access support to help mitigate their moral distress.

Due to their personal limitations, the participants could not always alter morally distressing situations to reflect their moral judgements. Therefore, in some circumstances, they had to come to an agreement that they were not going to alter anything. Diana forewarned that when coming to this agreement, individuals should never just give up on the situation. They should continue to advocate for what they believe is right and exhaust all of the resources that

they can. They still need to have the discussions with physicians and families to relay the message of what they believe is right. If they are then unsuccessful, that is when they need to reach closure with the situation. She said:

It's either I choose to accept or choose to remain in a conflict with it. But at the same time, I cannot just say, "Okay, I accept that." No. You go through questioning, ups and downs, frustration. You go through frustration. I remember having discussions with the team on rounds like, "Why can't we try this?" Trying even to go around someone. We need to try to get the family around. So you need to still go through the steps. You need to go through the frustrations, the confrontations, the discussions, the reflections and just move with it.

By going through this process of advocating for their moral concerns, the participants were able to remain morally engaged within their practice. They did not normalize the experience of moral distress and give up when they were faced with it. Instead, they continually worked through the experience to reach closure.

Being able to reach closure was not an easy task. It required the participants to critically reflect upon the situation and evaluate the outcomes so that they could learn from it. They would also reflect upon what their efforts were and what could have been done differently. Diana explained that this self-reflection allowed her to look at morally distressing situations from a different perspective. She made the analogy that these different perspectives were like looking at a situation with different glasses. She stated:

It's like I can't change necessarily stuff but I can maybe look at it different. I can maybe use a different pair of glasses... Today I have to wear my pink glasses because I need them... I don't think you can work in ICU and not have self-reflection because it catches up to you.

The final step in reaching closure was coming to terms with the morally distressing situation. At this point, the participants would no longer think, *“I should’ve done this, should’ve done this. Said this.”* Diana explained that staying in that mindset *“stops you from moving to the next step because you’re stuck.”* Instead, she advised that one had to find the courage in themselves to take a step and come to terms with what had occurred. She explained that when individuals remain morally distressed, it is because they cannot reach the stage of closure. She further elaborated, *“It’s because you can’t bring it closure. You can’t close it, you’re stuck.”* By acknowledging and reflecting upon what one was experiencing, closure could then be achieved.

4.6 Summary of the Findings

Moral distress was a complex concept that the participants noted as occurring when they would complete an action that was inconsistent with their perception of what was right. Their knowledge of the right action was influenced by the values and obligations of the nursing profession that they believed they had to uphold. Moral distress was a prominent issue within the participants’ practices that would occur quite frequently. It arose from situations in which: patients’ wishes and prognoses were unclear, miscommunication existed, the participants related personally to their patients and/or their families, the decisions of patients’ families and physicians were questioned, and the care of patients who were dying was prolonged. These sources created moral distress as the participants were unable to uphold their professional ethical obligations to promote the well-being and comfort of patients, respect patient autonomy and informed decision-making, support a dignified death, and alleviate and prevent suffering. In response to these situations, the participants were impacted negatively on emotional, physical, and psychosocial levels. They were able to cope with these negative impacts using four main strategies. These strategies comprised of: having unique outlets for their emotions and stress,

avoiding the morally distressing issue at hand, seeking support from others, and coming to terms with the issue so that they could move forward from it.

4.7 The Follow-up Interview

Following the completion of the data analysis, the investigator met with four of seven participants for a second interview. The participants were provided with a three page, single-spaced summary of the data analysis which included descriptions of each theme and associated sub-themes, as well as a variety of succinct quotations from the different interviews. Each participant was asked to take time to carefully read through the summary. Upon completion, the investigator began audio-recording the interview which began with the broad question: “Do these findings reflect your experience of coping with moral distress?” These audio-recorded interviews were then transcribed verbatim and verified for accuracy by the investigator. The following comments were provided by the participants in response to the investigator’s question: *“I think that it looks like an excellent summary of everything we talked about and I think it is very representative of my feelings”* (Jen); *“I think this is definitely a good summary of how I have felt and talking to other nurses as well”* (Julia); *“I feel like this all resonates with me. I answered probably very similar to other people...This definitely accurately depicts my experience”* (Janice); *“It encompasses pretty well like multiple themes and pinpoints like a good variety of mechanisms for newer nurses, older nurses, and just different personalities as well because everybody will deal with it a different way”* (Valerie). They all stated that the summary accurately reflected their personal experiences.

Chapter 5: Discussion and Implications for Practice, Education and Research

5.1 Introduction

This chapter presents a discussion of the findings of the study, and provides implications for nursing practice, education and research at the level of Advanced Nursing Practice. Current literature is used to support the discussion and implications. Suggestions for future research are recommended. Lastly, the limitations of the study will be highlighted.

5.2 The Meaning of Moral Distress

When the participants described what moral distress meant to them, each participant shared the unique ways in which they were impacted personally. Situations that the participants recalled were those which elicited a high intensity of moral distress or that occurred frequently within their practice.

5.2.1 Descriptions of moral distress.

When asked what the concept meant to them, the participants frequently noted that moral distress occurred when they faced a situation where they could not enact their moral judgements to perform what was ‘right’. However, in the examples they provided of the sources of moral distress, not all of their experiences fit into this description. For example, when *Working with Uncertainty*, the participants felt distressed from being unable to readily distinguish what their patients’ wishes were so that they could identify what actions would be considered ‘right’. Another example was when patients articulated wishes for treatments that the participants disagreed with. In these circumstances, the patients made decisions that the participants believed would lead to poor outcomes. Even though respecting these wishes would have promoted patient autonomy (which would have been considered a ‘right’ action), the participants were morally conflicted as they felt they were instead contributing to patient suffering. Traditionally, moral

distress has been defined as occurring when one is constrained from pursuing what is right (Jameton, 1984; Wilkinson, 1988). However, the examples of working with uncertainty and disagreeing with patients' wishes do not align with this definition. The definition of moral distress could therefore be broadened to encompass the range of experiences that arise for individuals when they encounter moral conflicts that cause them tension. This moral conflict creates a literal distortion between what is occurring within practice and what one's moral beliefs are.

When the participants experienced moral distress from conflicts where they felt they were constrained from enacting their moral beliefs, the importance of perception also arose. The participants were cognizant that their perception of the right action could differ from the perspective of others (such as physicians and patients and/or their families). They were also able to identify that others could possess different cultural, spiritual and religious beliefs with which they could disagree. Both Jameton's (1984) and Wilkinson's (1988) definitions of moral distress assume that when nurses experience moral distress, the moral decision that they made would have led to definitive right choice of action. However, as Johnstone et al. (2015) contend, it is not sufficient to deem a course of action as being morally correct solely because it supports a nurse's opinion. The participants' accounts of moral distress supported Johnstone et al.'s (2015) critique because they recognized that their moral decisions might not have always necessarily led to the correct course of action when examining the situation from an ethical perspective. Instead, in these circumstances, they were cognizant that they *perceived* that they knew what consisted as being right.

5.2.2 Perceptions of the right action: Where do they stem from?

Understanding how the participants determined the right course of action was complex. Each participant indicated that their perception was subjective as their moral beliefs could differ from others. However, multiple commonalities existed between what the participants believed was 'right'. When they experienced moral distress from *Working with Uncertainty*, *Dealing with Miscommunication*, *Resonance*, *Questioning the Decisions of Others*, and *Prolonging Care*, the same moral beliefs had been compromised for the participants. They felt unable to perform actions that would have led to promoting the well-being and comfort of patients, respecting patient autonomy and informed decision-making, supporting a dignified death, and alleviating and preventing suffering. These actions were inconsistent with what the CNO (2009) practice standards and the 'Canadian Code of Ethics for Registered Nurses' (CNA, 2008a) expects from nurses. These two sources highlight that nurses have four vital responsibilities: to promote health, prevent illness, restore health and alleviate suffering (CNA 2008a; CNO, 2009). These expectations of nurses date back decades and have traditionally been viewed as what the nursing profession is dedicated to uphold (Carper, 1978).

According to Peter and Liaschenko (2013), moral responsibilities are the actions that nurses are specifically accountable for within their practice. These responsibilities are reiterated to nurses through practice standards and the Code of Ethics, and are then further cultivated through professional socialization within the practice environment (Peter & Liaschenko, 2013). Professional socialization is the process in which nurses begin to recognize and embrace their moral identities within practice (Peter & Liaschenko, 2013). These moral identities are socially constructed and nurses develop them through the roles they adopt and the manner in which they see themselves (Peter & Liaschenko, 2013).

Within this study, the participants' moral responsibilities influenced their perception of what was 'right'. Being able to uphold basic nursing values, such as those reflected in the practice standards and the 'Code of Ethics', was integral to protecting the moral identities that the participants assumed within practice. They associated their identity with that of a helper who would maintain patients' best interests. However, with repeated exposure to morally distressing situations, the participants began believing that they were contributing to their patients' pain and suffering due to factors outside of their control. Being able to meet the ideals that the participants had set for patient care was vital to maintaining their moral identities and when they were unable to do so, they re-examined their nursing role.

5.3 The Influence of Hierarchical Power

Within the study, the participants' experiences of moral distress were characterized by feelings of "*powerlessness*". For decades it has been captured within the nursing literature that nurses often feel powerless in their positions (Barlem et al., 2013; Deady & McCarthy, 2010; Elpern et al., 2005; Gutierrez, 2005; Nathaniel, 2006; Sundin-Huard & Fahy, 1999; Wiegand & Funk, 2012; Wilkinson, 1988). The nurses in the current study described the relationships they had with patients and their families and due to their continual presence at the bedside, they felt that they should be advocates for patients. However, in many situations where they believed patient care was being compromised, they lacked the power to alter the circumstances. As a result, their moral agency was constrained. They felt that they could not change patients' care plans to reflect their moral judgements.

The participants of this study did indicate that they were in a position in between physicians and patients' families. When they questioned the decisions of these stakeholders, they believed they lacked the power necessary to alter the situation and instead were obliged to accept

those decisions. Hamric (2001) describes that nurses possess a unique, vulnerable position within their practice. Hamric (2001) terms this position as being “in the middle”, meaning between other stakeholders such as physicians and patients and their families (p. 255). This position can create moral challenges for nurses when their personal values conflict with the values of these other stakeholders (Hamric, 2001). In these instances, nurses can feel as though they have competing obligations related to enacting what is right for the patient, while also having to execute treatments based on physicians’ and patients’ families’ decisions.

Conflicts with the decisions made by physicians has frequently been noted as a source of moral distress for critical care nurses (Choe et al., 2015; Cronqvist et al., 2004; Gutierrez, 2005; Oberle & Hughes, 2001; Shorideh et al., 2012). Nurses can feel responsible for executing orders made by physicians even when they may question them or disagree with them (Peter & Liaschenko, 2013). It has been contended that there is a hierarchy of power where physicians are in a position of authority that is above nurses (Erlen, 2001; Hamric, 2000; Oberle & Hughes, 2001; Shorideh et al., 2012). Physicians are ultimately responsible for decisions related to patient care, so they can dismiss or ignore nurses’ opinions and moral concerns (Newton, Storch, Makaroff, & Pauly, 2012). Nurses can therefore be placed in a position where they feel they do not have a large degree of authority or significant input in decision-making. These are the situations in which nurses may be accustomed to accepting these circumstances and not exploring what might be possible.

According to Northouse (2001), power is defined as “the capacity or potential to influence” (p. 6). Power has been explored from a positive or ‘power with’ (Benner, 1984) or ‘power over’ (Hawks, 1991) orientation. Manojlovich (2007) describes that power allows individuals to influence others. To practice autonomously, nurses need to cultivate power so that

they can influence other stakeholders such as patients and their families, and physicians (Manojlovich, 2007). Ponte et al. (2007) conducted interviews with nurse educators, managers, clinical nurse specialists, and other nurses in leadership roles to obtain their perceptions of the characteristics of a powerful nursing practice. They identified powerful nurses as nurses who are confident in their knowledge of what patients and families need and can act on this knowledge through relationships to improve patient care.

Within this study, the participants with less nursing experience were the ones who felt more powerless within their practice. The nurses with many years of experience felt more as though their perspective was important and valued within practice. Heland (2006) found that critical care nurses who felt that their input in decision-making was valued had extensive nursing knowledge, multiple years of experience, and were confident in their ability to articulate their concerns. Issues can arise however for newer nurses within critical care who have not yet acquired these skills and abilities. For these nurses, it can be arduous for them to recognize what exactly the nursing perspective encompasses and how they can effectively articulate it to physicians. Hospitals are institutions with hierarchical structures that must be navigated. When nurses do not explore what might be possible, they risk conforming to the values of those in positions of power (Barlem et al., 2013; Calvin et al., 2009). Though being able to articulate the nursing perspective can be difficult, it is a skill that can be acquired for critical care nurses through experience (Heland, 2006).

5.4 Moral Distress: Is it Recognized?

The participants perceived that nursing management was unaware of the distressing events that occurred within their practice. Small gestures were made by nursing management such as sending out e-mails to nursing staff to say thank you after particularly busy shifts, but the

participants felt that the frequency of these gestures were minimal compared to the amount of times that they experienced moral distress. Debriefing sessions, where the participants could have opportunities to discuss, share and reflect upon morally distressing situations, were also seldom made available to them. Even when the participants felt significant moral distress in a specific patient situation, their patient assignments would remain unchanged. The only time a patient assignment would be altered was if they approached a charge nurse and specifically requested a change. However, most of the participants felt uncomfortable to do so as they believed that it would appear as though they were unable to handle their patient assignment.

The participants believed that their work environments gave little to no consideration of their experiences. As a result, the participants spoke of having to ‘fake it’ and hide their emotions. They would have to pretend as though they were unaffected by situations that were causing them moral distress. When the participants felt that they could not go into work because of the distress they were experiencing, they did not believe that they could tell nursing management the truth. Instead, they would report a fake illness and take a sick day. In Gutierrez’s (2005) study, critical care nurses felt that nursing management was completely oblivious to the moral distress that they experienced. They also did not believe that nursing management realized the extent of moral conflicts that existed within their practice.

Nurses cannot be expected to provide optimal patient care if there is no recognition of the distress that they experience within their workplaces. Not acknowledging moral distress can have far reaching consequences. Due to the lack of support that the participants felt, a few of them had indicated that they had considered leaving the nursing profession or their positions within the ICU. Lack of support was originally linked as a reason why many nurses leave their practices by Kramer (1974) and has continued to be strongly associated with nurse attrition (MacKusick &

Minick, 2010; Young, Stuenkel, & Bawel-Brinkley, 2008). According to the Canadian Institute for Health Information (2015), Canada's supply of nurses has been declining and in 2014, more nurses left the profession than entered. Many studies have indicated that nurses have left their positions or the profession as a direct result of having their moral values compromised (Elpern et al., 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Nathaniel, 2006; Piers et al., 2012; Sundin-Huard & Fahy, 1999; Wiegand & Funk, 2012; Wilkinson, 1988; Wilson et al., 2013).

When moral distress is unaddressed within practice, there is also a risk for nurses to develop moral residue (Epstein & Hamric, 2009). Epstein and Hamric (2009) describe moral residue as "the lingering feelings after a morally problematic situation has passed" (p. 332). Moral residue occurs with repeated exposure to moral distress (Epstein & Hamric, 2009). When a morally challenging situation concludes, nurses' moral distress may decrease but not completely cease (Epstein & Hamric, 2009). As they further experience moral distress, stronger reactions (emotionally, physically, and psychosocially) can be induced as they become reminded of their past experiences (Epstein & Hamric, 2009). If left unaddressed, nurses can feel increasing amounts of moral residue, which can be extremely damaging to their biopsychosocial health (Epstein & Hamric, 2009). Based on the descriptions of some of the participants of this study, it was possible that they were experiencing moral residue. For example, some of the situations that had caused them moral distress in the past continued to elicit emotions such as sadness and frustration for them. These emotions were the 'lingering feelings' of moral residue that they continued to experience.

5.5 Remaining Morally Engaged within Practice

The participants of this study were able to remain morally engaged within their practice despite the moral distress they experienced. In situations where they completely disagreed with the treatment plan, they would continue to provide patients with quality nursing care. Even when they had significant conflicting values with patients' families, they would care for the patient and not request a change in assignment because they felt that they had the most comprehensive understanding of their patients' circumstances and needs. The participants of this study were able to cope with moral distress without resorting to moral disengagement. They exhibited self-awareness and recognized when their moral beliefs and judgements were being compromised. They knew that to provide optimal patient care, they had to remain morally engaged in their practice. They strongly valued therapeutic nurse-patient relationships and strived to maintain them by contributing to the well-being of patients. Maintaining these commitments to patient care was a part of their moral identities.

Nurses must have the skills to cope with moral distress. Otherwise, they may morally disengage themselves as a way of coping so that they can perform actions that are inconsistent with their personal and professional moral beliefs without having to feel distressed (Fida et al. 2016). The risk of moral disengagement is that it can damage nurses' moral identities. It can cause nurses to become less proactive in their practice as they can avoid helping other workers, work less hours, and become less involved within their work units (Fida et al. 2016). Patient care becomes compromised because nurses who are morally disengaged can avoid patients and/or their families (Austin, et al., 2003; Barlem et al., 2013; Gutierrez, 2005; Kelly, 1998), emotionally withdraw from them, and minimize interactions with them (Barlem et al., 2013; Gutierrez, 2005).

5.5.1 The importance of connecting with others.

To cope with moral distress, every participant sought and connected with others for support. They considered nursing to be a profession that required team work and socialization. Therefore, they relied on their colleagues to be a source of support. When the participants connected with others, it was imperative that this support came from someone who “got it”. These were the individuals who were able to fully comprehend the morally distressing situation without having to be explained the ICU context of care or what different medical terminology meant. These individuals were able to grasp the situation because they had likely experienced something similar to it within their own past experiences.

Support from peers is considered to be extremely important in helping nurses cope with stress symptoms (de Boer, van Rikxoort, Bakker & Smit, 2013). It can improve one’s physical and psychological health, and enhance one’s ability to cope with stress (Ozbay et al., 2007). Seeking support from colleagues has been noted as a common strategy to cope with moral distress in a number of studies (Deady & McCarthy, 2010; Gutierrez, 2005; McClendon & Buckner, 2007; Zavotsky & Chan, 2016). Nurse colleagues are often selected as sources of support because of the empathy that they can offer (Gutierrez, 2005). They can identify with, and understand, the moral distress that their colleagues have experienced without making judgements.

For nurses to be able to access social support within practice, they must have the appropriate surroundings. The participants in this study described the importance of having a safe haven, meaning a physical space that they could use to speak to others in private. For many of the participants, their safe haven was the break room. However, some would avoid the break room because they saw it as a potentially toxic environment where many nurses would gather to

complain and ‘vent’ about situations that distressed them. The break room was also a large setting and some did not feel comfortable revealing how they were feeling in front of numerous other nurses. Instead, these participants would choose to seek support from their colleagues in a private area outside of the unit.

De Boer et al. (2013) state that to sufficiently meet nurses’ needs for social support, they must be provided with the necessary conditions (such as having a quiet place and time to receive support). Nursing administration in ICUs should be able to provide nurses with access to private areas where they can connect with others for support when they are feeling distressed. Nurses must also be granted break time away from the bedside to do so. Break times allow nurses to have moments for personal leisure and downtime (Hurtado, Nelson, Hashimoto, & Sorensen, 2015). They have been shown to help reduce psychological distress and enhance nurses’ mental health (Hurtado et al., 2015). By providing nurses with an accessible quiet place and time away from the bedside, nursing administration will convey that the role of nurses is valued and that their well-being is strongly taken into consideration.

5.5.2 The influence of nursing experience on coping.

The participants’ level of nursing experience appeared to be an important factor that influenced how they coped with moral distress. Of the total seven participants, five had three years or less of ICU experience. While differences in experience levels first became evident during recruitment, they became further notable when comparing the participants’ interviews. The interviews were quite polarized as participants with less ICU experience spoke of coping quite differently than the more experienced participants. Those with less experience described it in a concrete manner. They would encounter moral distress, experience the negative impacts, and resort to their usual coping strategies to handle them. Accessing an outlet, connecting with

someone who got it, and avoiding the situation were the most commonly used strategies amongst these participants. As nursing experience level increased, the participants began questioning whether these coping strategies were more of distraction than a solution to their moral distress. They appeared to become more self-aware and would engage in self-reflection to re-evaluate their coping strategies and identify what was effective for them. These participants spoke of their experiences of coping with moral distress with wisdom. They recognized that coping was a process that evolved over time with increased experiences and the mentoring of staff nurses. They knew that if they did not learn to cope with moral distress, there was no way that they could continue on within their practice. Their moral identities had evolved and incorporated beliefs that when a morally distressing situation was impossible to alter, they had to learn to move forward from it.

The difference in coping exhibited by the participants of this study could be best explicated by Benner's (1984) novice to expert theory. According to the Benner's (1984) theory, when nurses acquire expertise or develop skills related to a specific event, they pass through five different levels: novice, advanced beginner, competent, proficient, and expert. Novices have little to no experience with the event and rely on what they have been taught to cue their actions (Benner, 1984). Advanced beginners have encountered the event a few times and have begun to understand the meaning of it (Benner, 1984). Competence is usually obtained after two to three years (Benner, 1984). Nurses at this stage begin to feel confident in their actions and demonstrate efficiency (Benner, 1984). They are able to assess problems from an abstract and analytical perspective and establish plans accordingly (Benner, 1984). Proficient nurses examine situations as wholes rather than in segments (Benner, 1984). They have a deep understanding of the event and recognize what is usually expected from it and how they should modify their responses

accordingly (Benner, 1984). They are aware of the different attributes and aspects of the event and can identify when it does not progress as it normally would (Benner, 1984). In the final stage, expert nurses are able to grasp the event with intuitive knowledge without relying on any rules or guidelines (Benner, 1984). They know exactly what needs to be done in response to it without having to waste time considering other options (Benner, 1984).

Benner's (1984) novice to expert theory helps in explaining the differences between how the participants coped with moral distress. They acquired coping skills as they progressed through their practice. The majority of the participants were at the competent or advanced beginner stage where they were starting to understand the concept of moral distress and establish different plans as to how they could cope. In contrast, the more experienced nurses who were at the proficient and expert stage were able to recognize fairly quickly when moral distress occurred in their practice and knew what strategies were most effective for them to cope. Since newer critical care nurses may lack the knowledge and skills necessary to be able to recognize and cope with moral distress, focus must be given to them. Experienced critical care nurses and nursing management should strive to mentor these newer nurses so that they can acquire these skills.

5.5.3 The ability to get yourself back up.

Being able to come to terms with a morally distressing event and reach closure was a difficult task, but it was essential. Rushton, Caldwell, and Kurtz (2016) state that “although nurses’ primary obligation is to their patients, they also have an obligation to address their own suffering” (p. 44). Dealing with moral distress involved being flexible and returning to a situation in a different way. Participants would advocate for what they believed was right in the situation and would have multiple discussions with physicians and families to reiterate their

moral concerns. They would make suggestions in interprofessional rounds on how patient care could be ameliorated, articulate their concerns to nursing management, and approach senior nurses for advice. They engaged in a process of learning how to manage distressing situations without normalizing them and becoming complacent with them. According to Rushton et al. (2016), moral distress can foster growth and be symbolic of moral conscientiousness. The participants exhibited growth as they learned from previous experiences and used their skills, experience, knowledge and confidence to work through moral distress. Just like the grass, their roots were firmly in place and they were able to withstand adversity. These participants were assertive and cognizant of their nursing values. When the wind blew and caused them to fall to the ground, these participants acknowledged their personal limitations in the situation. However, they were still able to apply their knowledge, experience and skills to engage in self-care so that they did not experience the negative effects of moral distress. They were confident in themselves in these situations, which in turn contributed to them feeling that they had power.

The strategy of getting yourself “*back up*” was the only coping strategy noted by the participants that did not lead to moral residue, as defined by Epstein and Hamric (2009). When the participants coped by accessing an outlet and avoiding the situation, they noted that these strategies helped minimize their moral distress but were more of a temporary distraction. As a result, they went on to develop moral residue. Their feelings of anger, sadness, frustration and helplessness extended past when the situation concluded and lingered with them. Consequently, when another morally distressing situation occurred within their practice that reminded them of a previous experience, the situation resonated with them and would cause a higher acuity of moral distress. In contrast, the participants that reached closure with their moral distress did not experience the longer-term effects of moral residue. They were able to rationalize that morally

distressing situations could not always be altered. Therefore, to manage them, they had to come to terms with them.

5.6 The Participants' Coping Strategies: Relating Practice to Theory

The manner in which the participants described the concept of coping was consistent with Lazarus and Folkman's (1984) stress and coping theory. Lazarus and Folkman (1984) define coping as the "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). The participants believed that coping was the method used to '*deal*' with events that they perceived as being unpleasant and stressful. It was the actions they took to handle their emotions and thought processes when they encountered these events.

Lazarus and Folkman (1984) explain that efforts made at coping include all actions and thoughts aimed at alleviating, avoiding or accepting the conditions perceived as causing stress. These different strategies were captured within the participants' experiences. When the participants felt distressed, efforts were made to alleviate it were evident when they would connect with others for support and/or access their personal outlets to help themselves unwind. Their efforts to avoid distressing conditions occurred when they would avoid thinking about what was causing them distress or removed themselves entirely from the situation. Lastly, they would engage in self-reflection about the morally distressing situation so that they would learn from it and move forward.

Within Lazarus and Folkman's (1984) stress and coping theory, coping is described as being process-oriented, meaning that it emphasizes how individuals actually act and think when a stressful situation is encountered (Folkman et al., 1986; Lazarus & Folkman, 1984).

Throughout the coping process, individuals appraise, reappraise and re-evaluate the situation by

focusing on what is occurring, what significance it possesses, and what measures can be taken (Lazarus & Folkman, 1984). The participants of this study also noted that coping was a process. For them, it entailed engaging in self-reflection to become knowledgeable of their strengths and areas to work at. Over time, by engaging in repeated reflection, they would become aware when coping strategies that were once useful for them had become ineffective. They would then re-evaluate their coping strategies and shift to utilizing a different method.

When comparing the participants' coping strategies to the stress and coping theory, other similarities were also noted. According to Folkman et al. (1986), a variety of coping strategies exist that individuals utilize when faced with distress. These strategies include confrontive coping (aggressive attempts made aimed at altering the situation), distancing (detaching oneself), self-control (regulating one's feelings), seeking social support (seeking informational and emotional support from others), accepting responsibility (accepting one's role), escape-avoidance (wishing that the situation would cease), planful problem-solving (attempts made at altering the situation through problem-focused interventions), and positive reappraisal (focusing on personal growth to find a positive meaning in the situation) (Folkman et al., 1986). The strategies used for coping are dependent upon the individual's appraisal of what is at stake (Folkman et al., 1986). The participants of this study used the 'seeking social support' strategy when they would connect with someone who "got it". They utilized the 'escape-avoidance' strategy when they would mentally or physically avoid the situation that was causing them distress. When the 'seeking social support' and 'escape-avoidance' strategies did not resolve the way that they were feeling, some of the participants became aware that they had to "get themselves back up" (similar to the strategy of positive reappraisal.) They reappraised what was at stake and recognized that their well-being could become compromised from the negative

impacts of moral distress. They therefore focused on their strengths and were able to grow as they worked through the situation and moved forward.

Folkman and Moskowitz (2004) later elaborated on the stress and coping theory to include meaning-based coping. Meaning-based coping signifies the cognitive strategies that are aimed at managing the meaning associated with a distressing situation (Folkman & Moskowitz, 2004). By using positive reappraisal as a way of coping, the participants altered what the morally distressing situation meant to them. They reflected upon their values and beliefs and realized that they were not in a position where they could enact them. However, instead of giving in to their feelings of moral distress and feeling helpless, they reappraised the situation and reflected on how they could learn from it, grow and move forward. By doing so, the meaning of the situation altered and became less morally distressing. Being able to move forward from the situation was quite different from normalizing moral distress. Instead of becoming complacent with it within their practice, they would continue to advocate for what they perceived was right. The participants were keenly aware when they would experience moral distress and used the situation as a learning opportunity where they focused on how they could apply their skills, knowledge and experience to work through their distress.

5.7 Resilience

Being able to cope successfully with moral distress by moving forward showed similarities to the concept of resilience. Resilience was a concept first used within psychiatric literature to describe children who appeared invulnerable when they encountered adverse situations within their lives (Earvolino-Ramirez, 2007). It is defined as the ability to pull through or cope in spite of significant adversity (Rutter, 1985). The term 'bouncing back' is often used to signify resilience as it involves moving on from adversity in a positive direction (Earvolino-

Ramirez, 2007). Dyer and McGuinness (1996) contend that resilience is defined by the attribute of being able to ‘rebound’ and carry on. Effective coping skills and having a sense of mastery are the skills needed to develop resilience (Dyer & McGuinness, 1996; Earvolino-Ramirez, 2007). Effective coping is defined as the ability to function at an optimal level once an adverse event is managed (Earvolino-Ramirez, 2007). Mastery is described as having great confidence, competence, skills and knowledge (Earvolino-Ramirez, 2007).

The concept of resilience could be used to explain how some of the participants were able to reach closure with moral distress within their practice. These participants exhibited effective coping as they were able to move forward from the distressing situation and return to functioning at an optimal level. Their sense of mastery was evident as they described that they had strong sense of who they were and what their thoughts, values, and beliefs were. They also had the confidence and courage necessary to be able to reach closure. These participants were able to stay resilient and cope successfully with moral distress despite the potential adversity that it could cause.

5.8 Implications for Nursing Practice, Education, and Research

The findings of this study are applicable to nursing practice, education and research. Their implications will now be presented, as well as recommendation for future work.

5.8.1 Nursing practice.

The findings of this study revealed that it may be impossible to eliminate moral distress from critical care nursing practice completely; therefore, interventions are needed to help mitigate it for nurses. Moral distress can have detrimental effects on nurses’ biopsychosocial health and if left unaddressed, can cause moral residue (Epstein & Hamric, 2009) and nurse attrition (MacKusick & Minick, 2010; Young et al., 2008). To prevent the development of moral

residue and potential attrition, nursing management must recognize, validate and address nurses' moral distress. Listening to nurses and validating their experiences of moral distress has been shown to help foster a sense of relief (Epstein & Hamric, 2009). Nursing management should regularly offer debriefing sessions to nurses whenever ethically challenging cases arise within practice. These sessions provide an opportunity to gather all of the individuals involved within the cases to discuss how they feel, evaluate the actions taken, and discuss what was learned (Bruce, Miller, & Zimmerman, 2015; Hamric, 2001). Regularly scheduling debriefing sessions will allow nurses to collaborate with other members of the healthcare team to learn about their perspectives and how to empathize with them, as well as build their skills to help manage challenging cases (Bruce et al., 2015).

Nursing management can also play a role in creating ethical work environments for nursing staff. These are environments in which moral issues are acknowledged, ethical practices are supported, inputs from staff regarding ethical issues are elicited (Gutierrez, 2005; Hamric & Blackhall, 2007; Wlody, 2007), and nurses' contributions and concerns are valued (Erlen, 2001). To foster ethical work environments, organizations should be structured in a manner to support nurses' roles, and their knowledge and skills. A shift is necessitated to have truly interprofessional presentations of patient cases. For example, when patient rounds occur, nursing input should be elicited so that a truly holistic perspective of the ethical issues present in a patient's case can be presented. As part of these environments, nursing management should also convey to nurses that they will be supported if they ever require time off work because of moral distress and reaffirm that they will never be reprimanded for it. They should be supportive in assisting these nurses in finding adequate resources to help manage their distress before they return to work. Improving collaboration between nurses and nurse managers will enhance

management's understanding of nurses' experiences and create opportunities for partnerships to help mitigate the effects of moral distress (Zavotsky & Chan, 2016). This collaboration will also help in legitimizing and validating nurses' experiences with moral distress and facilitate the promotion of their mental well-being within the work environment.

The participants' experiences of coping with moral distress also revealed that particular attention must be given to nurses who are new to critical care or only have a few years of experience. These nurses may not have developed their coping strategies to the extent where they can manage moral distress successfully. With time, the more experienced participants exhibited resilience as they successfully continued on in their practice despite the adverse effects that moral distress caused. Workshops could be implemented within organizations aimed at teaching nurses about different coping strategies that they can use and how they can foster skills such as self-reflection so that they can develop resilience. Those responsible for creating patient assignments should also be mindful of nurses who are new to the ICU. The participants of this study noted that they were often assigned for consecutive shifts to end-of-life situations. Nursing management should be cognizant that newer nurses also need to have patients who recover so that they can witness the spectrum of ICU care.

The majority of the participants of this study believed that there were no formal resources within their practice to help them cope with their distress. One resource that most of the participants were unaware existed was the Employee Assistance Program [EAP]. The EAP is a short-term confidential counselling service accessible to nurses which they can use for support when they encounter issues that impact their well-being at work. If long-term treatment is necessitated, the EAP can also refer nurses to community services. The EAP was seldom mentioned within this study and only one participant reported ever utilizing it. However, this

participant did not find the resource overly helpful as she found it difficult to explain what caused her distress to a counsellor who did not have an understanding of the context of her practice.

It is imperative that organizations have resources in place that can help nurses' coping processes. The participants expressed the importance of having a unique outlet (such as physical activity) to release the emotions and stress that they experienced. Organizations should provide nurses with access to different outlets such as exercise classes and yoga so that they can unwind at work. Organizations should also provide opportunities for personal and professional development to enhance nurses' knowledge of ethics and expertise. These opportunities can include educational sessions, involving nurses in projects on the unit meant to raise awareness about moral distress, and including nurses in leadership positions (such as within unit councils) where they can address the issue within practice. Lastly, organizations should promote the existing resources such as the EAP that they have. Information as to what these resources are and how they can be accessed should be readily available to all nurses.

The resource that the participants most frequently utilized was other colleagues with whom they would connect with for support as a means of coping with moral distress. These connections would allow the participants to understand how other nurses used their knowledge and skills to effect change in morally distressing situations. Research has revealed the importance of having supportive nursing relationships within practice to cope with stress symptoms (de Boer et al., 2013; Ozbay et al., 2007). However, nurses require a safe place and adequate time to connect with their colleagues. A shift should occur within the culture of organizations so that these important nursing needs are recognized. Organizations should also

strive to accommodate these needs by providing nurses with a quiet area they can access and enabling them to take time off the unit when they feel distressed at work.

Lastly, the participants described how miscommunication with physicians was a significant source of moral distress for them. To prevent this issue within practice, improved interprofessional communication is necessary. According to Peter and Liaschenko (2013), nurses have numerous moral responsibilities, but they work within an interprofessional environment where their ability to enact their responsibilities is dependent upon other team members recognizing and supporting them. Nurses must possess the skills necessary to effectively communicate their values and moral concerns to other members of the interdisciplinary team. Workshops can be implemented within practice aimed at providing nurses with the ability to recognize their values in patient care, as well as the communication skills necessary to be able to express their moral concerns. There should also be a shift in organizational culture to eliminate hierarchies and empower nurses to articulate their concerns to physicians and to others in administrative positions including nurse managers.

5.8.2 Education.

The participants of this study did not indicate receiving formal education regarding the different moral challenges that can arise within the ICU or how to cope with them. Exposure to the concept of moral distress should begin for nurses when they are students. They should have an understanding of when moral distress may become a threat to them in practice, and ways that they can cope with it. As nursing students, they should also be taught the process of self-reflection to become self-aware of their personal values and moral beliefs. Vanlaere and Gastmans (2007) argue that nursing students must be exposed to ethics education that provides them with skills to critically reflect on their practice. To cultivate continuing competence within

professional practice, students must be taught how to become aware of their self-consciousness through reflection and how to engage in continual critical reflection (Williams, 2001).

When nurses become oriented to the ICU, it is also important that formal education about moral distress and coping exists for them. Before entering ICU practice, they should be taught about the reality of critical care and the possible moral challenges that they can encounter. They should also be taught how to differentiate moral distress from other challenging practices that they may face. Challenging practices can evoke emotional distress, but lack moral components (McCarthy & Deady, 2008). For example, when nurses face situations in which they feel overworked, they may exhibit stress and other symptoms of emotional distress. However, these situations do not contain ethical or moral aspects. For nurses to be able to recognize when they are experiencing moral distress, they should be taught how to analyze situations to distinguish whether there is a moral component that is being challenged. Focus should also be given to teach the signs of moral distress and how to recognize them, as well the sources of support and resources that exist within the organization. By providing nurses with this knowledge, they will be more cognizant of the moral challenges they can face and will be aware of what supports are in place for them to utilize. Lastly, nurses should be taught how to deconstruct a practice situation to pinpoint what is distressing about it and what personal values are being compromised within it. By recognizing what values are being compromised within a situation, nurses will be able to articulate with better clarity the reasoning behind their moral distress.

Lastly, organizations could provide educational opportunities for nurses and physicians to learn to improve their moral dialogue. Educational sessions with a focus on team-based communication can teach nurses how to remain self-aware during collective decision-making and how to facilitate communication amongst individuals who are fraught with emotion (Bruce

et al., 2015). Within these sessions, nurses and physicians could be provided with a hypothetical, ethically challenging clinical case to work through together. These sessions could relay the importance of teamwork, communication and respect for the input of others.

5.8.3 Research.

The participants of this study revealed that different coping strategies existed between newer nurses and more experienced ones. Further research is needed to confirm whether coping evolves over time and if the coping strategies that nurses use differ based on their experience level. Future research is also needed to determine the link between resilience and moral distress and explore how newer critical care nurses can become resilient within their practice.

This study revealed how miscommunication between nurses and physicians can cause significant amounts of moral distress for nurses. In many circumstances, the participants felt that their moral concerns were not acknowledged by physicians. Future research is needed to explore how moral dialogue can be facilitated amongst nurses and physicians. Research is also needed to determine what resources can be instituted within organizations to help nurses and physicians understand each other's moral concerns.

Lastly, the lack of formal resources or support systems in place within the participants' organizations made it difficult for them to cope with their moral distress. Further research is needed to explore different interventions aimed at alleviating moral distress within organizations. More research is also required to determine what formal support systems are useful to nurses so that they can cope successfully.

5.9 Implications for Advanced Nursing Practice

This study's findings are applicable to advanced nursing practice. According to the CNA's (2008b) Advanced Nursing Practice Framework, advanced nursing practice is "an

umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations” (p. 9). Advanced practice nurses (APNs) have four core competencies: clinical, research, leadership, and consultation and collaboration (CNA, 2008b). The implications for APNs related to each of these competencies will be discussed.

5.9.1 Clinical.

At the clinical level, APNs work in conjunction with patients and members of the health care team to provide comprehensive care (CNA, 2008b). They use theory, research, clinical experience and nursing knowledge to meet the needs of the organizations in which they work (CNA, 2008b). The ICU is a complex area of practice due to its potential for generating moral challenges and would benefit from advanced nursing practice.

APNs can play an important role within ICUs in recognizing signs of moral distress amongst nurses. Helping nurses recognize that they are exhibiting moral distress can be therapeutic for them as their experiences become validated. When nurses are able to label what they are experiencing as moral distress, they are more likely to take action to resolve it (CNA, 2003). APNs can offer support to them and be a trusting resource available to listen and empathize with them. Listening to nurses and validating their experiences of moral distress has been shown to help foster a sense of relief (Epstein & Hamric, 2009).

APNs can prevent the ramifications of moral distress and assist nurses in coping with it by planning and creating educational sessions within organizations. Sessions could be aimed at improving interdisciplinary communication or providing nurses with strategies to cope with moral distress. When improving interdisciplinary communication, sessions could be conducted

where nurses, physicians and other members of interdisciplinary team meet, discuss hypothetical patient cases and work together to resolve the moral conflicts that are presented within them (Gutierrez, 2005). Other sessions APNs can conduct can target nurses and teach them the signs of moral distress and different coping strategies they can use to manage it. APNs can be extremely helpful in mitigating moral distress through educational sessions. They can help nurses use their personal knowledge and skills to bring about changes to practice so that they have a greater voice in decision making. Beumer (2008) explained how an APN-led workshop was created that incorporated discussions of moral distress, individualized plans to help reduce distress, and strategies to cope (Beumer, 2008). When nurses who completed this workshop were followed-up with, they reported that their moral distress had diminished (Beumer, 2008). For these educational sessions to become integrated into practice, APNs should organize and develop them. They could then promote their importance amongst the unit and seek nurses, physicians and interdisciplinary team members to participate.

5.9.2 Research.

As part of their research competency, APNs conduct research, synthesize research for use in practice and implement evidenced-based practices (CNA, 2008b). APNs in critical care can evaluate the current practices that exist within their organizations related to how nurses are supported. They can then help mitigate moral distress for critical care nurses by utilizing research. They can review empirical studies that have exhibited how to minimize moral distress amongst ICU nurses and implement their strategies within practice. For example, research has shown that nurses can experience moral distress when their input is not taken into consideration during patient decision-making (Gutierrez, 2005). APNs can assist nurses in effectively putting themselves forward so that they can be recognized and valued for the knowledge and skills that

they possess. APNs can ensure that during patient rounds, nurses are encouraged to share their inputs and concerns related to patient care so that some situations may never become stressful for them. Research has also shown that the use of ‘ethics rounds’ can help prevent moral distress amongst nurses (Gutierrez, 2005; Wlody, 2007). Ethics rounds offer a non-judgemental atmosphere where an ethicist, the interdisciplinary team and patients and/or their families gather to discuss their moral concerns regarding patient care (Gutierrez, 2005; Wlody, 2007; Zuzelo, 2007). By having their moral concerns heard and recognized, nurses can experience less moral distress (Gutierrez, 2005). APNs can begin by reviewing the empirical evidence that has shown the effectiveness of ‘ethics rounds’. They can then create a policy where these rounds would be a mandatory practice within ICUs.

5.9.3 Leadership.

For the leadership competency, APNs advocate for change, find new ways to enhance practice, and shape organizations to improve the quality and delivery of care (CNA, 2008b). APNs’ leadership roles are extremely important within critical care practice. They can help lead organizations in shifting their structures so that nurses’ roles, values and input are well supported. APNs can help challenge the hierarchical structures of institutions so that nurses feel empowered to work with those in positions of power. They can work with physicians and nurses to facilitate an environment where the two professions work together without overpowering one another.

As leaders, APNs can help create ethical work environments within ICUs where nurses would not be frequently subjected to moral distress. They can promote the qualities of respect, trust and open communication which are essential to these environments (Erlen, 2001). They can encourage nurses to voice their moral concerns and assure them that their contributions and

concerns are valued. APNs can inspire nurses and nurse managers to develop a vision of what they believe an ethical work environment would look like and lead them in creating it.

5.9.4 Consultation and collaboration.

The consultation and collaboration competency encompasses the capability to collaborate and consult with others at different organizational, provincial, national and international levels (CNA, 2008b). APNs can be a source of support for nurses who are faced with morally distressing situations by employing their consultation and collaboration competency. When there are complex patients who present ethical issues within the ICU, APNs can recognize the need to consult an ethicist or the ethics committee. When nurses have uninterrupted access to an ethicist, they are given some ability to clarify and act upon their moral convictions (AACN, 2008).

Though consulting ethicists may be helpful, they may not be available as timely as necessary (Zuzelo, 2007). They may be more required when there are significant ethical dilemmas and moral disagreement amongst members of the interdisciplinary team (Zuzelo, 2007). APNs can therefore fill this gap by creating a Moral Distress Consult Service that is available for nurses to consult. When consulted, an APN can come to the unit to discuss the case, validate the nurses' experiences of moral distress, and review the actions that have been taken (Epstein & Hamric, 2009). They can then help nurses find ways to address and manage their distress (Epstein & Hamric, 2009).

5.10 Limitations

This study sought to explore critical care nurses' experiences of coping with moral distress. Qualitative research allows for knowledge related to human experience to be generated with great depth and context rather than to create findings that generalizable to a population (Thorne, 2008). Therefore, the findings of this study may not be reflective of all critical care

nurses who have experienced this phenomenon. Also, the experiences that the participants shared were influenced by the environment of a particular academic hospital affiliated with a university. As such, their experiences may not reflect the experiences of nurses who have worked in other environments such as community hospitals or non-teaching hospitals.

Another limitation of the study was that all of the participants were Caucasian females. With the lack of male input, the investigator was unable to deduce whether gender influenced the experience of coping with moral distress. Given that the participants were also all Caucasian, the impact of culture on the experience of coping with moral distress could not be explored. Morals are influenced by an individual's religion, family, life experiences and cultural background (McClendon & Buckner, 2007; Riesch et al., 2000). Therefore, different cultures may possess dissimilar moral values. Future research comparing the influence of culture on the experience of coping with moral distress is needed.

A third limitation of this study was related to the eligibility criteria. Participants were required to self-identify that they had experienced moral distress at least once at work. The study's participants were cognizant of what moral distress meant and different situations in practice where they had identified that they had experienced it. With this eligibility criterion, nurses who did not use the term 'moral distress' to label their challenging experiences were not necessarily captured within the sample. These nurses may have in reality experienced moral distress but could have labelled it differently.

Lastly, the sample's participants were fairly new in critical care as the majority of them had three years or less of ICU experience. There was a lack of participation from nurses who had extensive experience in critical care. Only one of the participants had over 25 years of critical care experience. The findings of this study therefore may not be reflective of all nurses who have

been practicing in critical care for many years. The impact of nursing experience on one's ability to cope with moral distress is a topic of inquiry that requires further research.

5.11 Conclusion

The findings of this study contributed to an understanding of the experiences of critical care nurses in coping with moral distress. Four interrelated themes emerged from the shared experience of seven critical care nurses. These themes cannot be examined in isolation. Rather when combined, they develop a story. The story begins with *Going Against What I Think is Best*, meaning a moral conflict arises. The source of this conflict is captured within *Moral Distress- It's Just Inherent in Our Job*. When nurse face these sources, they experience the negative consequences of moral distress, which are explicated by *It Just Felt Awful*. In response to these negative impacts, nurses engage in a process of coping to help mitigate their distress, which was depicted in the final theme *Dealing with It*. The experience of coping with moral distress had an overarching theme of being "like grass in the wind." Despite the hardship that moral distress would cause, over time, the participants learned how to use their skills, experience, and knowledge to work through their moral distress. Just like the grass, their roots were firmly in place and they held true to their nursing values, so they were able to withstand adversity and get themselves "back up."

Critical care nurses work in a challenging environment where despite recognizing their professional ethical obligations, they do not always have the ability to enact them. Findings from this study will help improve our understanding of the concept of moral distress as defined by the participants rather than from traditional definitions. Their definition was much broader and captured the range of experiences that occur when nurses encounter moral conflicts that cause them tension. This study's findings also helped create an understanding of what the process of

coping looks like when nurses are faced with moral distress. This study revealed that nurses' experience levels can influence this coping process as nurses with less experience may have more difficulty in being able to cope effectively with their moral distress. In comparison, nurses with many years of experience who remain morally engaged in their practice are able to cope with distress as they exhibit resilience. These findings contribute to new nursing knowledge and extend to practice, education and research. The knowledge generated from this study contributes ways in which critical care nurses can be supported within organizations so that they can cope effectively with the moral distress that they may experience.

References

- Abeloff, M. D., Armitage, J. O., Lichter, A. S., & Niederhuber, J. E. (2000). *Clinical Oncology* (2nd ed.). Edinburg, NY: Churchill Livingstone.
- American Association of Critical-Care Nurses. (2004). The 4A's to rise above moral distress. Retrieved from http://www.aacn.org/wd/practice/docs/4as_to_rise_above_moral_distress.pdf
- American Association of Critical-Care Nurses. (2008). Moral distress position statement. Retrieved from http://www.aacn.org/WD/Practice/Docs/Moral_Distress.pdf
- Appley, M. H., & Trumbull, R. (1967). *Psychological stress: Issues in research*. New York, NY: Appleton Century Crofts.
- Aronson, J. (1995). A pragmatic view of thematic analysis. *The Qualitative Report*, 2(1), 1-3. Retrieved from <http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html>
- Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experience of moral distress. *Nursing Inquiry*, 10(3), 177-83. doi:10.1046/j.1440-1800.2003.00181.x
- Barlem, E. L. D., Lunardi, V., Lunardi, G., Tomaschewski-Barlem, J., & da Silveira, R. (2013). Moral distress in everyday nursing: Hidden traces of power and resistance. *Revista Latino-Americana De Enfermagem*, 21(1), 293-9. doi:10.1590/S0104-11692013000100002
- Benner, P. (1984). *From novice to expert*. Menlo Park, CA: Addison-Wesley Pub.

- Bergum, V. (2004). Relational ethics in nursing. In P. A. Rodney, J. L. Storch, & R. C. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 485-503). Toronto, ON: Pearson Prentice Hall.
- Beumer, C. (2008). Innovative solutions: The effect of a workshop on reducing the experience of moral distress in an intensive care unit setting. *Dimensions of Critical Care Nursing*, 27(6), 263-7. doi:10.1097/01.DCC.0000338871.77658.03
- Browning, A. (2013). Moral distress and psychological empowerment in critical care nurses caring for adults at end of life. *American Journal of Critical Care*, 22(2), 143-51. doi:10.4037/ajcc2013437
- Bruce, C. R., Miller, S. M., & Zimmerman, J. L. (2015). A qualitative study exploring moral distress in the ICU team: The importance of unit functionality and intrateam dynamics. *Critical Care Medicine*, 43(4), 823-831. doi:10.1097/CCM.0000000000000822
- Burkhardt, M. A., & Nathaniel, A. K. (2014). *Ethics & issues in contemporary nursing* (4th ed.). Stanford, CT: Cengage Learning.
- Calvin, A., Lindy, C., & Clingon, S. (2009). The cardiovascular intensive care unit nurse's experience with end-of-life care: A qualitative descriptive study. *Intensive and Critical Care Nursing*, 25(4), 214-20. doi:10.1016/j.iccn.2009.05.001
- Canadian Association of Critical Care Nurses. (2009). Standards for critical care nursing practice. Retrieved from <http://www.caccn.ca/en/pdfs/CACCN%20STND%20CRIT%20CARE%202009.pdf>

- Canadian Critical Care Society. (2014). The role of ICU: What to expect. Retrieved from http://www.canadiancriticalcare.org/about/patients_families#.Vifgvn6rTIU
- Canadian Institute for Health Information. (2015). Supply of nurses in Canada declines for first time in two decades. Retrieved from https://www.cihi.ca/en/nurses_2014_pubsum_en.pdf
- Canadian Nurses Association. (2003). Ethical distress in health care environments. Retrieved from http://cna-aiic.ca/~media/cna/page-content/pdfen/ethics_pract_ethical_distress_oct_2003_e.pdf?la=en
- Canadian Nurses Association. (2008a). Code of ethics for registered nurses. Retrieved from <http://www.cna-aiic.ca/~media/cna/files/en/codeofethics.pdf>
- Canadian Nurses Association. (2008b). Advanced nursing practice: A national framework. Retrieved from http://www.cna-aiic.ca/~media/cna/page-content/pdf-en/anp_national_framework_e.pdf
- Carnevale, F. A. (2013). Confronting moral distress in nursing: Recognizing nurses as moral agents. *Revista Brasileira De Enfermagem*, 66, 33-38. doi:10.1590/S0034-71672013000700004
- Carper, A. B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13-24.
- Choe, K., Kang, Y., & Park, Y. (2015). Moral distress in critical care nurses: A phenomenological study. *Journal of Advanced Nursing*, 71(7), 1684-1693.

- College of Nurses of Ontario. (2009). Practice standard: Ethics. Retrieved from http://www.cno.org/globalassets/docs/prac/41034_ethics.pdf
- Cook, D., Rocker, G., Marshall, J., Sjøkvist, P., Dodek, P., Griffith, L., . . . Guyatt, G. (2003). Withdrawal of mechanical ventilation in anticipation of death in the intensive care unit. *The New England Journal of Medicine*, 349(12), 1123-1132. doi:10.1056/NEJMoa030083
- Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing*, 33(2), 250-6.
- Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636-650. doi:10.1191/0969733002ne557oa
- Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, 12(4), 381-90.
- Cronqvist, A., Theorell, T., Burns, T., & Lützén, K. (2004). Caring about-caring for: Moral obligations and work responsibilities in intensive care nursing. *Nursing Ethics*, 11(1), 63-76. doi:10.1191/0969733004ne667oa
- Davies, B., Clarke, D., Connaughty, S., Cook, K., MacKenzie, B., McCormick, J., & Stutzer, C. (1996). Caring for dying children: Nurses' experiences. *Pediatric Nursing*, 22(6), 500-7.
- de Boer, J., van Rikxoort, S., Bakker, A. B., & Smit, B. J. (2013). Critical incidents among intensive care unit nurses and their need for support: Explorative interviews. *British Association of Critical Care Nurses*, 19(4), 166-174.

- Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care*, 46(3), 209-220. doi:10.1111/j.1744-6163.2010.00260.x
- Distress. (2016). In *Merriam-Webster online*. Retrieved from <http://www.merriam-webster.com/dictionary/distress>
- Dyer, J., & McGuinness, T. (1996). Resilience: An analysis of the concept. *Archives of Psychiatric Nursing*, 10(5), 276–282.
- Earvolino-Ramirez, M. (2007) Resilience: A concept analysis. *Nursing Forum*, 42(2), 73-82.
- Efstathiou, N., & Walker, W. (2014). Intensive care nurses' experiences of providing end-of-life care after treatment withdrawal: A qualitative study. *Journal of Clinical Nursing*, 23(21), 3188-3196. doi:10.1111/jocn.12565
- Elpern, E., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care*, 14(6), 523-30.
- Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics*, 20(4), 330-342.
- Erlen, J. A. (2001). Moral distress: A pervasive problem. *Orthopedic Nursing*, 20(2), 76-80. doi:10.1097/00006416-200103000-00015
- Ferrell, B. (2006). Understanding the moral distress of nurses witnessing medically futile care. *Oncology Nursing Forum*, 33(5), 922-30. doi:10.1188/06.ONF.922-930

- Fida, R., Tramontano, C., Paciello, M., Kangasniemi, M., Sili, A., Bobbio, A., & Barbaranelli, C. (2016). Nurse moral disengagement. *Nursing Ethics, 23*(5), 547–564.
- Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*(5), 992-1003. doi:10.1037/0022-3514.50.5.992
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology, 55*, 745-74.
- Forchuk, C. (1991). Ethical problems encountered by mental health nurses. *Issues in Mental Health Nursing, 12*(4), 375-83.
- Fry, S., Harvey, R., Hurley, A., & Foley, B. (2002). Development of a model of moral distress in military nursing. *Nursing Ethics, 9*(4), 373-87. doi:10.1191/0969733002ne522oa
- Ganz, F., Raanan, O., Khalaila, R., Bennaroch, K., Scherman, S., Bruttin, M., & Benbenishty, J. (2013). Moral distress and structural empowerment among a national sample of Israeli intensive care nurses. *Journal of Advanced Nursing, 69*(2), 415-24. doi:10.1111/j.1365-2648.2012.06020.x
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

- Gutierrez, K. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, 24(5), 229-41. doi:10.1097/00003465-200509000-00011
- Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook*, 48(5), 199-201. doi:10.1067/mno.2000.110564
- Hamric, A. B. (2001). Reflections on being in the middle. *Nursing Outlook*, 49(6), 254-7. doi:10.1067/mno.2001.120247
- Hamric, A. B., & Blackhall, L. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, 35(2), 422-9. doi:10.1097/01.CCM.0000254722.50608.2D
- Hawks, J. H. (1991). Power: A concept analysis. *Journal of Advanced Nursing*, 16(6), 754-762.
- Heland, M. (2006). Fruitful or futile: Intensive care nurses' experiences and perceptions of medical futility. *Australian Critical Care*, 19(1), 25-31.
- Heyland, D., Cook, K., Ricker, D., Dodek, J., Kutsogiannis, G., Peters, M., . . . O'Callaghan, D. (2003). Decision-making in the ICU: Perspectives of the substitute decision-maker. *Intensive Care Medicine*, 29(1), 75-82.
- Hurtado, D. A., Nelson, C. C., Hashimoto, D., & Sorensen, G. (2015). Supervisors' support for nurses' meal breaks and mental health. *Workplace Health & Safety*, 63(3), 107-115.
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice-Hall.

- Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing*, 4(4), 542-51.
- Johnstone, M. (2004). *Bioethics: A nursing perspective* (4th ed.). Sydney, NY: Churchill Livingstone.
- Johnstone, M., Hutchinson, A., & Peter, E. (2015). 'Moral distress' – Time to abandon a flawed nursing construct? *Nursing Ethics*, 22(1), 5-14. doi:10.1177/0969733013505312
- Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P., & Arnetz, B. (2004). Living with conflicts- Ethical dilemmas and moral distress in the health care system. *Social Science & Medicine*, 58(6), 1075-1084. doi:10.1016/S0277-9536(03)00279-X
- Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing*, 28(5), 1134-45. doi:10.1046/j.1365-2648.1998.00810.x
- King, P., & Thomas, S. (2013). Phenomenological study of ICU nurses' experiences caring for dying patients. *Western Journal of Nursing Research*, 35(10), 1292-1308. doi:0193945913492571
- Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St Louis, CV: Mosby.
- Kroh, M., & Hurlock-Chorostecki, C. (2009). A shared staffing model for two critical care environments. *Canadian Nurse*, 105(2), 23-25.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Pub.

- Lee, K. J., & Dupree, C. Y. (2008). Staff experiences with end-of-life care in the pediatric intensive care unit. *Journal of Palliative Medicine, 11*(7), 986-990.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- MacKusick, C. I., & Minick, P. (2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *Medsurg Nursing, 19*(6), 335-340.
- Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Online Journal of Issues in Nursing, 12*(1), 1-15.
- McAndrew, N., Leske, J., & Garcia, A. (2011). Influence of moral distress on the professional practice environment during prognostic conflict in critical care. *Journal of Trauma Nursing, 18*(4), 221-30. doi:10.1097/JTN.0b013e31823a4a12
- McCarthy, J., & Deady, R. (2008). Moral distress reconsidered. *Nursing Ethics, 15*(2), 254-62.
- McClendon, H., & Buckner, E. (2007). Distressing situations in the intensive care unit: A descriptive study of nurses' responses. *Dimensions of Critical Care Nursing, 26*(5), 199-206. doi:10.1097/01.DCC.0000286824.11861.74
- Meltzer, L., & Huckabay, L. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care, 13*(3), 202-8.
- Mobley, M., Rady, M., Verheijde, J., Patel, B., & Larson, J. (2007). The relationship between moral distress and perception of futile care in the critical care unit. *Intensive and Critical Care Nursing, 23*(5), 256-63. doi:S0964-3397(07)00031-6

- Morse, J. M., & Field, P. A. (1996). *Nursing research: The application of qualitative approaches* (2nd ed.). Thousand Oaks, CA: Chapman & Hall.
- Munhall, P. (1994). *Revisioning phenomenology: Nursing and health science research*. New York, NY: National League for Nursing Press.
- Nathaniel, A. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research*, 28(4), 419-38. doi:10.1177/0193945905284727
- Newton, L., Storch, J., Makaroff, K., & Pauly, B. (2012). "Stop the noise!" From voice to silence. *Nursing Leadership*, 25(1), 90-104.
- Northouse, P. G. (2001). *Leadership: Theory and practice* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Oberle, K., & Hughes, D. (2001). Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *Journal of Advanced Nursing*, 33(6), 707-15.
- Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. E., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: From neurobiology to clinical practice. *Psychiatry (Edgmont)*, 4(5), 35-40.
- Peter, E., & Liaschenko, J. (2004). Perils of proximity: A spatiotemporal analysis of moral distress and moral ambiguity. *Nursing Inquiry*, 11(4), 218-225.

- Peter, E., & Liaschenko, J. (2013). Moral distress reexamined: A feminist interpretation of nurses' identities, relationships, and responsibilities. *Journal of Bioethical Inquiry: An Interdisciplinary Forum for Ethical and Legal Debate*, 10(3), 337-345. doi:10.1007/s11673-013-9456-5
- Piers, R., Van den Eynde, M., Steeman, E., Vlerick, P., Benoit, D., & Van den Noortgate, N. J. (2012). End-of-life care of the geriatric patient and nurses' moral distress. *Journal of the American Medical Directors Association*, 13(1), 80-13. doi:10.1016/j.jamda.2010.12.014
- Polit, D. F. & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Ponte, R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrell, R., ... Washington, D. (2007). The power of professional nursing practice: An essential element of patient and family centered care. *Online Journal of Issues in Nursing*, 12(1), 1-9.
- Raines, M. L. (2000). Ethical decision making in nurses: Relationships among moral reasoning, coping style, and ethics stress. *JONA's Healthcare Law, Ethics, and Regulation*, 2(1), 29-41. doi:10.1097/00128488-200002010-00006
- Rice, E., Rady, M., Hamrick, A., Verheijde, J., & Pendergast, D. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management*, 16(3), 360-73.

Ridner, S. H. (2004). Psychological distress: Concept analysis. *Journal of Advanced Nursing*, 45(5), 536–545.

Riesch, S. K., Von Sadowsky, V., Norton, S., & Pridham, K. F. (2000). Moral reasoning among graduate students in nursing. *Nursing Outlook*, 48(2), 73-80. doi:10.1016/S0029-6554(00)90006-X

Robley, L. R. (2008). From ethics to palliative care: A community hospital experience. *Nursing Clinics of North America*, 43(3), 469-476. doi:10.1016/j.cnur.2008.04.010

Rodgers, B. L. (2000). Concept analysis: An evolutionary view. In B. L. Rodgers & K. A. Knafel (Eds.), *Concept development in nursing: Foundations, techniques and applications* (2nd ed.). Philadelphia: Saunders.

Rushton, C., Caldwell, M., & Kurtz, M. (2016). Moral distress: A catalyst in building moral resilience. *American Journal of Nursing*, 116(7), 40-49.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598–611.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18(2), 179-183. doi:10.1002/nur.4770180211

- Shorideh, A. F., Ashktorab, T., & Yaghmaei, F. (2012). Iranian intensive care unit nurses' moral distress: A content analysis. *Nursing Ethics, 19*(4), 464-78. doi:10.1177/0969733012437988
- St Ledger, U., Begley, A., Reid, J., Prior, L., McAuley, D., & Blackwood, B. (2013). Moral distress in end-of-life care in the intensive care unit. *Journal of Advanced Nursing, 69*(8), 1869-80. doi:10.1111/jan.12053
- Sundin-Huard, D., & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorizing the relationships. *International Journal of Nursing Practice, 5*(1), 8-13. doi:10.1046/j.1440-172x.1999.00143.x
- Supreme Court of Canada. (2013). Cuthbertson v. Rasouli. Retrieved from <http://eol.law.dal.ca/wp-content/uploads/2013/10/Cuthbertson-v-Rasouli-2013-SCC-53.pdf>
- Thorne, S., Kirkham, S. R., & Macdonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*(2), 169-177.
- Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), 1-11.
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Ulrich, C. M. & Mooney-Doyle, K. (2012). What does the future hold for nursing care? In C. M. Ulrich (Ed.), *Nursing ethics in everyday practice* (pp. 3-4). Indianapolis, IN: Sigma Theta Tau International.

- Vanlaere, L., & Gastmans, C. (2007). Ethics in nursing education: Learning to reflect on care practices. *Nursing Ethics, 14*(6), 758-66. doi:10.1177/0969733007082116
- Wallen, G. R., & Baker, K. (2012). Ethical challenges in transitioning to end-of-life care: Exploring the meaning of a "good death". In C. M. Ulrich (Ed.), *Nursing ethics in everyday practice* (pp. 150-152). Indianapolis, IN: Sigma Theta Tau International.
- Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing, 53*(4), 459-469.
- Wiegand, D. L., & Funk, M. (2012). Consequences of clinical situations that cause critical care nurses to experience moral distress. *Nursing Ethics, 19*(4), 479-487.
doi:10.1177/0969733011429342
- Wilkinson, J. (1988). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29. doi:10.1111/j.1744-6198.1987.tb00794.x
- Williams, B. (2001). Developing critical reflection for professional practice through problem-based learning. *Journal of Advanced Nursing, 34*, 27-34.
- Williams, G. F., Fullbrook, P. R., Alexandrov, A. W., Montanez, W. C., Salisu-Kabara, H. M., & Chan, D. W. K. (2009). Intensive and critical care nursing perspectives. In A. Gullo, J. Besso, P. D. Lumb, & G. F. Williams (Eds.), *Intensive and critical care medicine* (pp. 119-134). Verlag, Italy: Springer.

- Wilson, M. A., Goettemoeller, D. M., Bevan, N. A., & Mccord, J. M. (2013). Moral distress: Levels, coping and preferred interventions in critical care and transitional care nurses. *Journal of Clinical Nursing*, 22(9), 1455-1466. doi:10.1111/jocn.12128
- Wlody, G. S. (2007). Nursing management and organizational ethics in the intensive care unit. *Critical Care Medicine*, 35(2), 29-35.
- Young, M. E., Stuenkel, D. L., & Bawel-Brinkley, K. (2008). Strategies for easing the role transformation of graduate nurses. *Journal for Nurses in Staff Development*, 24(3), 105-112.
- Zavotsky, K. E., & Chan, G. K. (2016). Exploring the relationship among moral distress, coping, and the practice environment in emergency department nurses. *Advanced Emergency Nursing Journal*, 38(2), 133-146. doi:10.1097/TME.0000000000000100
- Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, 14(3), 344-359. doi:10.1177/0969733007075870

Appendix A: English Recruitment Flyer

SEEKING ICU NURSES TO VOLUNTEER FOR A RESEARCH STUDY

STUDY TITLE: Critical Care Nurses' Experiences of Coping with Moral Distress

STUDY PURPOSE The purpose of this study is to understand critical care nurses' experiences of coping with moral distress.

**Moral distress refers to the distress that individuals experience when they are prevented from enacting what they believe is right.*

This study is being conducted by Dana Forozeiya, a Master of Science in Nursing student at the University of Ottawa, under the supervision of Dr. Brandi Vanderspank-Wright and Dr. Frances Fothergill Bourbonnais of the School of Nursing at the University of Ottawa.

WHO CAN PARTICIPATE?

Registered nurses who:

- Are employed full-time or part-time within the intensive care unit,
- Have completed orientation,
- Have had at least one experience of feeling morally distressed at work,
- Are fluent in English or French.

WHAT IS INVOLVED?

You will be asked to participate in two face-to-face interviews with the researcher (Dana Forozeiya). The first interview will be approximately 30-60 minutes in length and the second interview will be around 20 minutes long. In the first interview, you will be asked some questions about your experiences of coping with moral distress. In the second interview, you will be asked to review a summary of the study's findings in order to determine whether it reflects your experiences. Interviews will be completed at a place and time that is convenient to you. All of the information that you provide will be de-identified, therefore you will not be identifiable in any publications or presentations resulting from the study

WHO DO I CONTACT?

If you would like to participate in this study or want more information, please contact Dana Forozeiya.

This research study has been reviewed and approved by the Ottawa Health Science Network Research Ethics Board.

Appendix B: French Recruitment Flyer

INFIRMIER(ÈRES) D'USI RECHERCHÉ(E)S POUR PARTICIPER À UNE ÉTUDE DE RECHERCHE

TITRE DE L'ÉTUDE : L'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale.

BUT DE L'ÉTUDE Le but de cette étude est de comprendre l'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale.

** La détresse morale est la détresse que les individus éprouvent quand ils sont empêchés de faire ce qu'ils croient être juste.*

Cette étude est menée par Dana Forozeiya, une étudiante à la maîtrise en sciences infirmières de l'Université d'Ottawa, sous la supervision de Dr. Brandi Vanderspauk-Wright et de Dr. Frances Fothergill Bourbonnais de l'École des sciences infirmières de l'Université d'Ottawa.

QUI PEUT PARTICIPER?

Les infirmiers/infirmières autorisé(e)s qui:

- Sont employé(e)s à temps plein ou à temps partiel sur une unité de soins intensifs,
- Ont complété(e)s leur orientation,
- Ont vécu au moins une expérience où ils/elles ont éprouvé de la détresse morale au travail,
- Parlent l'anglais ou le français couramment

QU'EST-CE QUE CELA IMPLIQUE?

Vous serez demandé à participer à deux entrevues en tête à tête avec la chercheuse (Dana Forozeiya). La première entrevue sera d'une durée approximative de 30 à 60 minutes et la seconde entrevue prendra environ 20 minutes. Durant la première entrevue, on vous demandera quelques questions concernant les situations dans lesquelles vous avez fait face à la détresse morale. Puis, lors de la deuxième entrevue, on vous demandera de réviser un sommaire des résultats de l'étude afin de déterminer si ceux-ci reflètent vos expériences.

Les entrevues auront lieu à un endroit et à un moment de la journée qui seront opportuns pour vous. Toutes les informations que vous nous fournissez seront dépersonnalisées, donc vous ne serez pas identifiable dans les publications ou présentations résultant de cette étude.

QUI DOIS-JE CONTACTER?

Si vous souhaitez participer à cette étude ou si vous voulez plus de renseignements, s'il vous plaît contactez Dana Forozeiya.

Cette étude a été approuvée par le Conseil d'éthique de la recherche du Réseau de science de la santé d'Ottawa.

Appendix C: English Recruitment E-mail Script

Attention ICU nurses,

A study is currently being conducted at the Civic and General intensive care units entitled “Critical Care Nurses’ Experiences of Coping with Moral Distress”. The purpose of this study is to understand critical care nurses’ experiences of coping with moral distress.

**Moral distress refers to the distress that individuals experience when they are prevented from enacting what they believe is right.*

To participate, you must be a registered nurse who:

- Is employed full-time or part-time within the intensive care unit,
- Has completed orientation,
- Has had at least one experience of feeling morally distressed at work,
- Is fluent in English or French.

Participants in this study will be asked to partake in two face-to-face interviews with the researcher (Dana Forozeiya). The first interview will be approximately 30-60 minutes in length and the second interview will be around 20 minutes long. In the first interview, you will be asked to describe your experiences of coping with moral distress. In the second interview, you will be asked to review a summary of the study’s findings in order to determine whether it reflects your experiences. These interviews will be completed at a place and time that is convenient to you. All of the information that you provide will be de-identified, therefore you will not be identifiable in any publications or presentations resulting from the study

This study is being conducted by Dana Forozeiya, a Master of Science in Nursing student at the University of Ottawa. This study is under the supervision of Dr. Brandi Vanderspank-Wright and Dr. Frances Fothergill Bourbonnais of the School of Nursing at the University of Ottawa.

If you would like to participate in this study or want more information, please contact Dana Forozeiya.

Appendix D: French Recruitment E-mail Script

Attention infirmier(ères) d'USI,

Une étude est actuellement menée dans les unités de soins intensifs aux Campus Civic et Général. Le titre de cette étude est "L'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale."

Le but de cette étude est de comprendre l'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale.

** La détresse morale est la détresse que les individus éprouvent quand ils sont empêchés de faire ce qu'ils croient être juste.*

Les infirmiers/infirmières autorisé(e)s qui peuvent participer:

- Sont employé(e)s à temps plein ou à temps partiel sur une unité de soins intensifs,
- Ont complété(e)s leur orientation,
- Ont vécu au moins une expérience où ils/elles ont éprouvé de la détresse morale au travail,
- Parlent l'anglais ou le français couramment

Dans cette étude, vous serez demandé à participer à deux entrevues en tête à tête avec la chercheuse (Dana Forozeiya). La première entrevue sera d'une durée approximative de 30 à 60 minutes et la seconde entrevue prendra environ 20 minutes. Durant la première entrevue, on vous demandera quelques questions concernant les situations dans lesquelles vous avez fait face à la détresse morale. Puis, lors de la deuxième entrevue, on vous demandera de réviser un sommaire des résultats de l'étude afin de déterminer si ceux-ci reflètent vos expériences. Les entrevues auront lieu à un endroit et à un moment de la journée qui seront opportuns pour vous. Toutes les informations que vous nous fournissez seront dépersonnalisées, donc vous ne serez pas identifiable dans les publications ou présentations résultant de cette étude.

Cette étude est menée par Dana Forozeiya, une étudiante à la maîtrise en sciences infirmières de l'Université d'Ottawa, sous la supervision de Dr. Brandi Vanderspank-Wright et de Dr. Frances Fothergill Bourbonnais de l'École des sciences infirmières de l'Université d'Ottawa.

Si vous souhaitez participer à cette étude ou si vous voulez plus de renseignements, s'il vous plaît contactez Dana Forozeiya.

Appendix E: English Information/Consent Form



Participant Informed Consent Form

Title of the study: *Critical Care Nurses' Experiences of Coping with Moral Distress*

Principal Investigator:

Dr. Brandi Vanderspank-Wright, RN, Ph.D.

Co-Investigators:

Dana Forozeiya, RN, B.Sc.N.

Dr. Frances Fothergill Bourbonnais, RN, Ph.D.

Funding: Nursing Professional Practice

Participation in this study is voluntary. Please read this informed consent form carefully and ask the investigator as many questions as you like before you decide if you would like to participate.

Why am I being given this form?

You are being asked to participate in this study because you are a critical care nurse who has experienced moral distress.

Why is this study being done?

Moral distress refers to the distress that individuals experience when they are prevented from enacting what they believe is right. Little is known about how critical care nurses cope with moral distress. The purpose of this study is to describe critical care nurses' experiences of coping with moral distress, understand how critical care nurses describe coping, and identify what strategies critical care nurses use to cope with moral distress.

We estimate that 12 participants will be enrolled in this study.

What is expected of me?

You will be asked to participate in two face-to-face interviews. These interviews will take place outside of your work hours at a time and quiet place that is convenient to you.

The first interview will be approximately 30-60 minutes in length. During the first interview, you will be asked a few questions regarding your experiences of coping with moral distress. You may answer the questions in as much detail as you feel comfortable. You may choose to not answer any of the questions or end the interview at any time.

The second interview will take place approximately 2 months after your first interview. The study team will contact you by e-mail to arrange a time and place to meet that is convenient for you. This interview will be around 20 minutes long. In this interview, you will be asked to review a summary of the study's findings to determine whether it reflects your experiences.

Both interviews will be audio-recorded to ensure that there is an accurate record of the information that you have shared. Prior to each interview you will be asked to choose a pseudonym (false name) to be referred to so your name will not be present in the audio recording. The audio recordings will be transcribed, but again, your real name will not appear in the transcriptions; only a pseudonym. After transcription, the audio-recording of your interview will be deleted.

Your signed consent form will be kept at the University of Ottawa campus in a locked cabinet in Dr. Frances Fothergill Bourbonnais' office. Copies of your interview transcripts will be stored in a separate location at the University of Ottawa campus in a locked cabinet in Dr. Vanderspank-Wright's office. All electronic data will be kept on a USB key that will be encrypted and password protected.

You will not be identifiable in any presentation or publications that will arise from the study. Any publications or presentations will describe critical care nursing from a broad perspective (i.e. nurses working in critical care areas such as the intensive care unit). Your verbatim quotes may be included in presentations and publications, but your identity will not be revealed. All publications and presentations will avoid as many descriptors as possible when describing the setting/sample so that you and unit in which you work are not readily identifiable.

This study is interested in critical care nurses' general experiences of coping with moral distress rather than the particulars of specific cases that they have experienced. Therefore, if any statements are made that could be damaging to others, they will be removed from the study data if they are not conducive in understanding nurses' experiences with moral distress.

How long will I be involved in the study?

The entire study will last approximately 4 months. Your participation in the study will last approximately 2 months. Over this time, you will be required to visit the agreed upon location on two occasions.

What are the potential risks I may experience?

Your participation in this study will require that you recall experiences where you have felt morally distressed. These experiences may cause you to feel uncomfortable. The study team will make every effort possible to minimize this risk. If at any time you do not want to continue the interview, the interview can be stopped and rescheduled (if you choose to do so). You can refuse to answer any questions that you do not feel comfortable with. If you choose to no longer participate in the study, all of your information will be omitted from the study and destroyed.

The audio recordings will be sent offsite via an encrypted password protected USB key for transcription. As you will have selected a pseudonym name, the audio recordings will not contain any personal identifying information.

Can I expect to benefit from participating in this research study?

You will not receive any direct benefit from participating in this study. However, your participation in this study may help contribute to the advancement of nursing knowledge. The information that you provide may help to create an understanding of how nurses cope with moral distress. Your participation may also help identify ways for nurses to be supported when they experience moral distress.

Will I be paid for my participation or will there be any additional costs to me?

There is no compensation for this study. There are no costs to you.

Do I have to participate? What alternatives do I have? If I agree now, can I change my mind and withdraw later?

Your participation in this study is voluntary. The alternative to this study is not to participate. You may decide not to be in this study, or to be in the study now, and then change your mind later. Withdrawing from the study will not affect your employment at The Ottawa Hospital. If you choose to withdraw from the study, please contact Dana Forozeiya (see contact information on page 1). If you choose to withdraw from the study, all of the data collected from you will be destroyed. Your paper records will be shredded and disposed in confidential waste and your electronic records will be deleted.

How is my personal information being protected?

- All information collected during your participation in this study will be identified with a unique study number, and will not contain information that identifies you, such as your name, address, etc.
- The link between your unique study number and your name and contact information will be stored securely and separate from your study records, and will be stored on a secure server.
- All hardcopy study documents, including the consent form, will be brought from the interview location to the University of Ottawa, where they will be stored. Any documents leaving The University of Ottawa will contain only your unique study number. This includes publications or presentations resulting from this study.
- Information that identifies you will be released only if it is required by law.
- For audit purposes only, your original study records may be reviewed under the supervision of Dr. Brandi Vanderspank-Wright's staff by representatives from:
 - the Ottawa Health Science Network Research Ethics Board (OHSN-REB),
 - the Ottawa Hospital Research Institute,
 - the University of Ottawa Research Ethics Board.
- Research records will be kept for 10 years, after this time they will be destroyed.

Questions about the Study

If you have any questions about this study, please contact Dana Forozeiya.

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) and University of Ottawa Health Sciences and Science Research Ethics Board have reviewed the plans for this research study. If you have any questions about your rights as a study participant, you may contact the Chairperson of the OHSN-REB or the Protocol Officer for Ethics in Research at the University of Ottawa.



Critical Care Nurses' Experiences of Coping with Moral Distress

Consent to Participate in Research

- I understand that I am being asked to participate in a research study about critical care nurses' experiences of coping with moral distress.
- This study was explained to me by Dana Forozeiya.
- I have read, or have had it read to me, each page of this Participant Informed Consent Form.
- All of my questions have been answered to my satisfaction.
- If I decide later that I would like to withdraw my participation and/or consent from the study, I can do so at any time.
- I voluntarily agree to participate in this study.
- I will be given a copy of this signed Participant Informed Consent Form.

Signatures

Participant's Printed Name

Participant's Signature

Date

Investigator Statement

I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks and benefits involved in taking part in this study.

Investigator's Printed Name

Investigator's Signature

Date

Appendix H: French Information/Consent Form



Feuille de renseignements et Formulaire de consentement

Titre de l'étude : *L'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale*

Chercheuse principale:

Dr. Brandi Vanderspank-Wright, inf. aut., Ph.D.

Co-chercheuses:

Dana Forozeiya, inf. aut., B.Sc.inf.

Dr. Frances Fothergill Bourbonnais, inf. aut., Ph.D.

Commanditaire: Pratique professionnelle en soins infirmiers

Votre participation à cette étude s'effectue sur une base entièrement volontaire. Veuillez lire ce formulaire de consentement soigneusement avant de décider si vous souhaitez y participer. Posez à la chercheuse de l'étude autant de questions que vous le souhaitez.

Pourquoi me remet-on ce formulaire?

On vous invite à prendre part à cette étude de recherche parce que vous êtes un infirmier ou une infirmière de soins critiques qui a fait face à la détresse morale.

Pourquoi effectue-t-on cette étude?

La détresse morale est la détresse que les individus éprouvent lorsqu'ils sont empêchés de faire ce qu'ils croient être juste. On en connaît très peu sur les moyens utilisés par les infirmiers et infirmières de soins intensifs pour faire face à la détresse morale. Le but de cette étude est de décrire l'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale, comprendre comment les infirmier(ère)s décrivent y avoir fait face et identifier les stratégies qui sont utilisées par les infirmier(ère)s de soins intensifs pour faire face à la détresse morale. Nous anticipons la participation d'environ 12 participants pour cette étude.

Que serai-je appelé à faire?

On vous demandera de participer à deux entrevues en tête à tête. Ces entrevues auront lieu en dehors de vos heures de travail, à un temps et un endroit calme qui seront opportuns pour vous.

La première entrevue sera d'une durée approximative de 30 à 60 minutes. Durant la première entrevue, on vous demandera quelques questions concernant les situations dans lesquelles vous

avez fait face à la détresse morale. Vous pouvez répondre aux questions avec autant de détails que vous le souhaitez, et que vous vous sentez à l'aise de mentionner. Vous pouvez choisir de ne pas répondre à aucune des questions ou de terminer l'entrevue à tout moment.

La deuxième entrevue aura lieu approximativement deux mois suivants la première entrevue. L'équipe de recherche vous contactera par courriel électronique pour planifier un temps et un moment de rencontre qui seront opportuns pour vous. Cette entrevue durera environ 20 minutes. Lors de cette entrevue, on vous demandera de réviser un sommaire des résultats de l'étude afin de déterminer si ceux-ci reflètent vos expériences.

Les deux entrevues seront enregistrées sous version audio afin de s'assurer que l'information que vous avez fournie est enregistrée de façon exacte. Avant chaque entrevue, on vous demandera de choisir un pseudonyme (faux nom) auquel on pourra se référer afin que votre nom ne soit pas mentionné sur l'enregistrement audio. L'enregistrement audio sera transcrit, mais encore là, votre vrai nom n'apparaîtra pas dans la transcription; seulement votre pseudonyme. Suite à la transcription, l'enregistrement audio de votre entrevue sera supprimé.

Votre formulaire de consentement signé sera conservé sur le campus de l'Université d'Ottawa à l'intérieur d'un classeur verrouillé, situé dans le bureau de Dr. Frances Fothergill. Les copies de transcription de vos entrevues seront préservées dans un autre classeur verrouillé qui est localisé dans le bureau de Dr. Vanderspank-Wright sur le campus de l'Université d'Ottawa. Toutes données électroniques seront sauvegardées sur une clé USB qui sera cryptée et protégée par mot de passe.

Il sera impossible de vous identifier à partir de toutes présentations ou publications qui découleront de cette étude. Toutes publications ou présentations décriront les soins infirmiers critiques selon une perspective large (c.-à-d. les infirmier(ère)s travaillant dans le secteur des soins critiques tel qu'un unité de soins intensifs). Vos citations textuelles pourraient être incluses dans les présentations ou publications mais votre identité ne sera pas révélée. Toutes publications éviteront autant que possible tous éléments descriptifs afin que vous et l'unité sur lequel vous travaillez ne soyez pas facilement identifiables.

Cette étude s'intéresse à l'expérience générale des infirmier(ère)s de soins critiques qui ont fait face à la détresse morale plutôt qu'aux détails de cas particuliers qu'ils/elles ont vécus. Ainsi, si une déclaration pouvait causer du dommage à un ou plusieurs individus, et si celle-ci n'est pas propice à la compréhension de l'expérience d'infirmier(ère)s ayant fait face à la détresse morale, elle sera enlevée des données collectées.

Quelle sera la durée de ma participation à cette étude?

L'étude complète durera environ 4 mois. Votre participation à l'étude durera environ 2 mois. Pendant cette période, vous devrez visiter l'endroit convenu à deux occasions.

Quels sont les risques possibles associés à ma participation à cette étude?

Votre participation à cette étude nécessitera que vous vous souveniez d'expériences où vous avez ressenti de la détresse morale. Ces expériences pourraient vous rendre inconfortable. L'équipe de l'étude fera tous les efforts possibles pour minimiser ce risque. Si à tout moment vous désirez arrêter l'entrevue, celle-ci pourra être interrompue et une autre rencontre pourra être planifiée (si cela vous convient). Vous pouvez refuser de répondre à toutes questions qui vous rendent inconfortable. Si vous choisissez de ne plus participer à l'étude, tous vos renseignements seront omis de l'étude et détruits.

Les enregistrements audio seront envoyés, pour leurs transcriptions, par clé USB cryptée et protégée par un mot de passe. Étant donné que vous aurez choisi un pseudonyme, les enregistrements audio ne contiendront aucune information personnelle qui pourrait vous identifier.

Puis-je m'attendre à retirer des bienfaits en lien avec ma participation à cette étude?

Vous ne bénéficierez pas directement de votre participation à cette étude. Par contre, votre participation à cette étude pourrait contribuer à l'avancement des connaissances en sciences infirmières. L'information que vous fournirez pourrait aider à comprendre comment les infirmiers et les infirmières font face à la détresse morale. Votre participation pourrait également aider à identifier certaines stratégies qui pourraient supporter ces infirmiers et infirmières lorsqu'ils/elles ressentent de la détresse morale.

Serai-je rémunéré(e) pour ma participation à cette étude ou encourrai-je des frais additionnels en prenant part à cette étude?

Vous ne serez pas rémunéré pour votre participation à cette étude de recherche. Il n'y aura aucun frais pour vous.

Suis-je tenu(e) de participer? Quelles sont mes autres options? Puis-je changer d'idée plus tard et mettre fin à ma participation?

Votre participation à cette étude est volontaire. L'alternative de cette étude est de ne pas y participer.

Vous pouvez décider de ne pas participer à cette étude, ou d'y participer maintenant, puis de changer d'idée plus tard. Votre retrait de l'étude n'affectera pas votre emploi à l'Hôpital d'Ottawa. Si vous décidez de vous retirer de l'étude, veuillez s'il vous plaît contacter Dana Forozeiya (voir les informations de contact sur la première page). Si vous décidez de vous retirer de l'étude, toutes les données collectées seront détruites. Tous les documents sous version papier seront déchetés et disposés parmi les déchets confidentiels et vos données électroniques seront supprimées.

Comment assurera-t-on la protection de mes renseignements personnels?

- Toute l'information collectée pendant votre participation sera identifiée par un numéro unique pour l'étude et ne contiendra aucun renseignement qui pourrait vous identifier, tels que votre nom, adresse, etc.

- Le lien entre votre numéro unique pour l'étude et votre nom et coordonnées sera conservé sur un serveur sécurisé.
- Tous documents papier de l'étude, incluant le formulaire de consentement, seront transportés du lieu de rencontre de l'entrevue vers l'Université d'Ottawa où ils seront conservés. Tous documents quittant l'Université d'Ottawa contiendront seulement votre numéro unique pour l'étude. Cela inclut les publications et/ou les représentations de l'étude.
- La divulgation de vos renseignements d'identification ne sera permise que si requise par la loi.
- Les représentants des établissements suivants pourront procéder à l'examen de vos dossiers médicaux originaux, sous la supervision du personnel du docteur Brandi Vanderspank-Wright, uniquement à des fins de vérification :
 - Le Conseil d'éthique de la recherche du Réseau de science de la santé d'Ottawa (CÉR-RSSO)
 - L'institut de recherche de l'Hôpital d'Ottawa
 - Le comité d'éthique de la recherche à l'Université d'Ottawa
- Les dossiers de recherche seront conservés pour une période de 10 années. Une fois la période de rétention terminée, tous les dossiers papier seront déchiquetés ou jetés aux rebuts confidentiels, et les fichiers électroniques seront supprimés.

Questions au sujet de l'étude

Si vous avez des questions au sujet de cette étude, s'il vous plaît contactez Dana Forozeiya.

Le Conseil d'éthique de la recherche du Réseau de science de la santé d'Ottawa (CÉR-RSSO) et le comité d'éthique de la recherche en sciences de la santé et sciences à l'Université d'Ottawa a révisé ce protocole. Pour toute question au sujet de vos droits à titre de sujet de recherche, veuillez communiquer avec le président du Conseil d'éthique de la recherche du Réseau de science de la santé d'Ottawa ou le Responsable d'éthique en recherche à l'Université d'Ottawa.



L'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale

Consentement à la participation à la recherche

- Je reconnais que l'on sollicite ma participation à une étude de recherche sur l'expérience d'infirmiers et d'infirmières de soins critiques qui ont fait face à la détresse morale.
- Dana Forozeiya m'a fourni les explications nécessaires au sujet de cette étude.
- J'ai pris connaissance de chacune des pages de ce Formulaire de consentement éclairé à l'intention du participant.
- On a répondu à toutes mes questions de manière satisfaisante.
- Si je décide plus tard au cours de l'étude de retirer mon consentement, il me sera possible de le faire en tout temps.
- Je consens volontairement à prendre part à cette étude.
- On me remettra un exemplaire signé de ce Formulaire de consentement éclairé à l'intention du participant.

Signature

 Nom du participant
 (en caractères d'imprimerie)

 Signature du participant

 Date

Énoncé de la chercheuse

J'ai expliqué soigneusement au participant de la recherche la nature de l'étude susmentionnée. À ce que je sache, le participant apposant sa signature à ce consentement reconnaît la nature, les exigences, les risques et les avantages que comporte sa participation à l'étude.

 Nom de la chercheuse
 (en caractères d'imprimerie)

 Signature de la chercheuse

 Date

Appendix G: English Interview Script

1. Describe to me what moral distress means to you.
2. Tell me about a situation that you have encountered where you experienced moral distress.
3. How does moral distress make you feel?
4. What impact has moral distress had on you?
5. What resources have you used in the past to help you cope with moral distress?
6. Which of these resources did you find to be effective for you?
7. Describe to me what coping means to you.
8. What sources of support have you accessed at work to help you cope with moral distress?
9. Tell me about some of the coping strategies you have used.
10. Is there anything you would like to add about your experience of moral distress or how you have coped with it?

Appendix H: French Interview Script

1. Décrivez-moi ce que la détresse morale signifie pour vous.
2. Racontez-moi une situation dans laquelle vous avez expérimenté de la détresse morale.
3. Comment est-ce que la détresse morale vous fait ressentir?
4. Quel impact a eu la détresse morale sur vous?
5. Quelle(s) ressource(s) avez-vous utilisée(s) dans le passé pour vous aider à surmonter la détresse morale?
6. Laquelle ou lesquelles de ces ressources a/ont été efficace(s) pour vous?
7. Décrivez-moi ce que surmonter la détresse morale signifie pour vous.
8. Quelle(s) source(s) de support avez-vous accédée(s) au travail pour vous aider à surmonter la détresse morale?
9. Décrivez-moi quelques-unes des stratégies que vous avez utilisées pour surmonter votre détresse morale.
10. Est-ce que vous aimeriez ajouter quelque chose à propos de vos expériences face à la détresse morale ou comment vous l'avez surmontée?