

MORAL DISTRESS IN MEDICAL SURGICAL NURSES

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By

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LIST OF ABBREVIATIONS

List of Abbreviations

AACN: American Association of Critical Care Nurses

ANOVA: Analysis of Covariance

ANA: American Nurses Association

CNA: Certified Nursing Assistant

CPR: Cardiopulmonary Resuscitation

DRG: Diagnosis-Related Group

ICU: Intensive Care Unit

IRB: Institutional Review Board

M: mean

MD: Medical Doctor/physician

MDS: Moral Distress Scale

NCBON: North Carolina Board of Nursing

p value: level of significance

r value: Pearson's correlation coefficient

RN: Registered Nurse

SD: Standard Deviation

U.S.: United States

ABSTRACT

MORAL DISTRESS IN MEDICAL SURGICAL NURSES

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Aim/Purpose The purpose of this mixed method study was to evaluate the intensity and frequency of moral distress in medical surgical nurses using the Moral Distress Scale (MDS). The study also included three qualitative questions to obtain descriptions of situations of moral distress, its impact on the nurse physically, emotionally, and spiritually and the effect on others (i.e. patient, family, colleagues, manager, organization, etc.).

Method The study was conducted on a random sample obtained from the North Carolina Board of Nursing database. The survey, containing a section for demographic questions, the MDS scale, and qualitative questions, was mailed to a sample of 1,000 self-identified medical surgical nurses who reside in the state of North Carolina

The mean and standard deviation were done on both the intensity and frequency of each of the 38 questions. Correlations were determined between each of the demographic characteristics and the intensity and frequency of the 38 questions. ANOVA single factor variance was analyzed between respondents and questions to verify there was statistically significant variance.

The three qualitative questions were evaluated for common themes using phenomenological methods. Triangulation was done to ensure the trustworthiness of the themes.

Results The results of the study indicated there were statistically significant correlations in the demographics and responses. Using Pearson's correlation coefficient and a $p < 0.01$, there was no significant correlations between demographics and the frequency of factors of the MDS. There was one positive and six negative correlations between age and experience related to intensity of moral distress. Overall medical surgical nurses in the study experienced low intensity and frequency of moral distress ($M = 2.17$, $M = 1.32$). Comparatively, respondents reported greater experiences of intensity than frequency. Moderate levels of moral distress related to staffing, incompetence of nurses, nursing assistants and physicians and futility of care. The most frequent distress centered on inadequate staffing, incompetence, and futility.

The most prominent theme in morally distressing situations was the lack of informed consent/disclosure. Nurses described how they were impacted emotionally, physically, and spiritually as well the effects of moral distress on colleagues, patients, and families. There were also accounts of burned out nurses leaving a unit or the profession.

Implications The implications of this study revealed that medical surgical nurses experienced moral distress with more intensity than frequency. This is vital information for nursing leaders concerned about turnover and the impact on staff. Nurse administrators have a responsibility to create a healthy organizational climate to alleviate burnout and prevent distressing situations.

Keywords: burnout, ethical climate, medical surgical nurses, moral distress, turnover

CHAPTER ONE: BACKGROUND AND RATIONALE FOR STUDY

Introduction

Moral distress has been a highly researched topic in healthcare for the last two decades. Research has been conducted on a variety of clinicians including nurses, physicians, pharmacists, and respiratory therapists (Corley, 2002; Hamrick & Blackhall, 2007; Sporrang, Hoglund, & Arnetz, 2006; Schwenzer & Wang, 2006). A larger number of studies centered on nursing indicated that this challenging dilemma continues to plague the profession as evidenced in nurses' work and practice environments (Corley, Minick, Elswick, & Jacobs, 2005). Although moral distress impacts other types of clinicians, nurses report greater frequency and intensity levels of moral distress (Hamrick & Blackhall, 2007). Research has not determined if this is due to the close proximity of the nurse at the bedside (Hamrick & Blackhall, 2007; Peter & Liaschenko, 2004). Over 80% of nurses have reported medium to high levels of moral distress (Corley, 2002). Moral distress has been found to contribute to turnover, burnout, and abandonment of the nursing profession (Corley, Elswick, Gorman, and Chlor, 2001; Guitierrez, 2005). With a current nursing shortage, the health care system and nurse leaders have a call to action to decrease or eradicate moral distress.

Clinicians face a multitude of complex challenges that include an increase in patients' co-morbid conditions, an extending life span, limited institutional resources, changes in reimbursement, and the shortage of clinical professionals. Changes in the financial landscape of health care organizations have added to the pressures. Hiring freezes, attrition, cuts in staff development and education, and alterations in staffing plans only further increase levels of stress. Often employees report staffing related issues and

conflict management as the most difficult stressors in their work environment (Corley, Minick, Elswick, & Jacobs, 2005). Therefore, one could identify why ethical issues and moral distress continue to exist in a sea of so many challenges.

Most research of moral distress in registered nurses (RNs) has been conducted in critical care areas, particularly adult intensive care units. The focus has been on these specialty units because of the significant challenges with patients facing end-of-life decisions and the struggle of health care professionals with appropriateness of care (Hamrick & Blackhall, 2007). Corley, Elswick, Gorman, and Chlor (2001) developed the Moral Distress Scale (MDS) to assess the level of intensity and frequency of moral distress (Appendix A). The components of the instrument were constructed to measure factors that contribute to moral distress; these factors are particularly focused on challenges in the critical care setting.

Medical surgical units have also been faced with an increase in patient acuity, staffing challenges, and utilization pressure. Staffing is a great concern for nurse managers and administrators; the goal is to provide quality care while balancing the cost of nursing and efficiency of staff (Brennan & Daly, 2009). "Studies of nursing work indicated that a nurse's work environment is closely related to nurse satisfaction and nurse turnover. Not only does nursing turnover result in the loss of experienced nurses, it is also costly – between \$60,000 and \$120,000 per nurse" (Storfjell, Omoike, & Ohlson, 2008, p. 244). This raises questions about levels of mortal distress among medical surgical nurses not only as a strategy to improve care but also to retain nursing staff.

Moral distress was first identified and defined in 1984 as “when one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right

course of action” (Jameton, 1984, p. 6). That definition was expanded to include not only institutional constraints but supervisory issues, the power structure of the medical staff, legal considerations, and lack of time (Corley et al., 2001). Essentially, moral distress is when an individual knows what ethical decision to make but feels like he/she cannot make it.

A recent study evaluated perceptions of moral distress among RNs compared to ethical climate. Findings showed a correlation between ethical climate and moral distress; the less ethical support within an organization, the greater the levels of moral distress (Pauly, Varcoe, Storch, & Newton, 2009). To date the majority of studies evaluating this correlation have used convenience samples. The studies were conducted within a limited number of organizations and therefore did not evaluate diverse settings. These convenience samples limit the ability to generalize the findings to broad numbers of medical surgical nurses (Pauly et al., 2009; Rice, Rady, Hamrick, Verheijde, & Pendergrass, 2008; Zuzelo, 2007). Demographic data including age and education level have not been found to impact moral distress levels. However, studies have shown a correlation between the ethical climate of an organization and the level of moral distress experienced by staff (Corley et al., 2005). This relationship is important for leaders and strategic planning.

Moral distress has been linked to turnover, job satisfaction, and burnout. In fact, studies have indicated that those nurses who experience high levels of moral distress are more likely to leave not only the institution but the also the profession. One particularly poignant study showed that 15% of nurses left a previous position because of moral distress; another study in 1999 indicated that level to be as high as 26% (Corley, 2002).

These outcomes show the significance of the workplace environment on retention of nurses.

Problem Statement

Moral distress is an ethical dilemma for clinical staff, particularly amongst nurses and has led to burnout, turnover, and abandonment of the nursing profession. At least one out of 10 have left a position due to moral distress (Corley et al., 2001). Over 80% of nurses experience moderate to high levels of moral distress (Corley, 2002). Moral distress impacts retention of nurses and therefore contributes to the nursing shortage. Numerous studies have documented the frequency and intensity of moral distress. Research has determined that critical care nurses experience moderate levels of moral distress particularly when they believe care is futile and other clinicians are incompetent (Hamrick & Blackhall, 2007).

Research has determined a correlation between the ethical climate of the organization and levels of moral distress. Other studies have focused on levels of moral distress among medical surgical nurses. However, most of these have been conducted within one health care organization (Pauly et al., 2009; Rice et al., 2008; Zuzelo, 2007). This is problematic in relating these study findings to all medical surgical nurses.

The purpose of this study was to assess levels of moral distress in a wide cross-section of medical surgical nurses from a variety of hospital and demographic settings. A mixed method study was conducted using the MDS scale as well as several qualitative questions (Appendix A). The survey was administered via mail to a random sample of medical surgical nurses working in acute care settings throughout the state of North Carolina. The MDS scale measured both the intensity and frequency of moral distress.

The qualitative data were analyzed using phenomenological methods to evaluate nurses' experiences.

Justification of the Study

This study of moral distress in medical surgical nurses is important because historically, specialty intensive care units (ICUs) have been the area of focus. With an increase in the acuity of medical surgical patients, there is an increase in pressure and stress on nurses in these clinical settings. Medical surgical nurses are a critical link in the system because the vast majority of acute care encounters are on these units. ICUs typically do not discharge patients, and medical surgical units are often the location for care coordination and transition to home, skilled nursing, or other level of care.

Another important reason for this study is that few randomized studies of moral distress have been conducted. Most of the studies of medical surgical nurses have been in one or two institutions or this population has been combined together with critical care nurses. Studies have shown that the ethical climate of an organization impacts the levels of moral distress (Pauly et al., 2009). This brings into question whether these studies can be generalized to medical surgical nurses because they were conducted within one organization and one ethical climate.

Study findings of moral distress provide leaders and administrators with information about how to develop programs to support their staff in situations of moral distress and ethical dilemmas. The American Academy of Critical Care Nurses (AACN) published a position statement that "moral distress is a critical, frequently ignored, problem in healthcare work environments. Unaddressed, it restricts nurses' ability to provide optimal patient care and to find job satisfaction" (AACN, 2008, p. 1). AACN

strongly advises health care organizations to implement programs to promote healthy work environments and reduce moral distress (AACN, 2008.). Other professional organizations may choose to follow suit depending on the findings of this study. Leaders have a responsibility to address moral distress because it impacts job satisfaction, retention, and patient care (Bell & Brisling, 2008). "Nurses have multiple ethical obligations, sometimes competing, sometimes conflicting, including those to the patient, the organization or institution in which they work, other healthcare professionals, and the nursing profession...Sometimes the nurse must decide to whom she or he owes a primary obligation. The [ANA] Code [of Ethics] says that the primary obligation is to the patient" (Fowler, 2010, p. 15). Therefore, moral distress is an ethical dilemma for nurses.

Theoretical and Conceptual Framework

The concept of moral distress originated from Andrew Jameton, a philosopher who published, *Nursing Practice: The Ethical Issues* (1984). He explained that nurses feel moral distress when they know the right thing to do but are unable to make that decision due to institutional constraints (Jameton, 1984). This distress could arise when doing unnecessary procedures, dealing with incompetent practitioners, experiencing conflicts with family wishes, or deciding about disclosure to the patient. Jameton further developed the concept of moral distress into two factors: initial and reactive (1993). Initial moral distress is described as the feelings of anxiety, anger, and frustration with institutional obstacles and conflict of interpersonal values (Corley, 2002). Reactive distress is exhibited when nurses experience distress because they did not act on the originating distress. This factor differentiation shows the compounding effect of an initial situation and subsequent outcomes.

Corley proposed a moral distress theory in 2002 that is based on Jameton's moral distress concept. She defined nursing as a moral profession that is grounded in ethical standards. These are reflected in nurse practice acts and standards of care. Corley described the moral distress theory and the relationships between concepts in a flow chart as illustrated in Appendix B. The theory expands from an explanation of moral distress to how it impacts the nurse, the patient, and the organization. The result of moral distress on the patient is a nurse who avoids the patient and does not act as an advocate. The impact of moral distress on the nurse is burn-out, resignation from a position, or abandonment of nursing. Corley (2002) proposed the impact that moral distress has on the institution is high nurse turnover, low patient satisfaction, and decreased quality of care. Ultimately, the theory predicts that these three issues can impact recruiting, reputation, and accreditation (Corley, 2002).

Assumptions

Nurses are ethical professionals who are primarily responsible to the patient. Nurses are also responsible to the organizations they work for. All nurses regardless of specialty or unit encounter ethical dilemmas and experience moral distress. Therefore, medical surgical nurses experience moderate levels of moral distress in their work environments. Those factors with the most amount of distress are linked to futility of care as evidenced in previous research (Hamrick & Blackhall, 2007; Rice et al., 2008).

Research Questions and Hypothesis

The research questions this study aimed to answer were as follows:

- What is the intensity level of moral distress in a random sample of medical surgical nurses?

- What is the frequency of moral distress in a random sample of medical surgical nurses?
- What factors contribute to the highest intensity and frequency levels of moral distress?
- Do levels of moral distress differ based on demographic characteristics i.e. age, years of experience, education level, etc.?

From the literature, this researcher predicted that medical surgical nurses experience moderate levels of moral distress in both intensity and frequency. The researcher also predicted that demographic characteristics would not exhibit a correlation with levels of moral distress.

Definition of Terms

Moral distress: the psychological disequilibrium one experiences when one knows the right ethical decision to make but cannot make it due to institutional constraints (Corley 2002)

Moral Distress Scale (MDS): 38 question Likert tool to measure both the intensity and frequency of moral distress. The instrument has found to be valid and reliable (Corley, et al., 2001)

Demographic characteristics: the factors within the population that allows for categorization. For example, age, location, workplace, etc.

Random: the process by which a sample is selected from a population that allows for equal probability for selection (Polit & Beck, 2008).

Correlation: a relationship or association between variables. One variation is systematically related to another and vice versa (Polit & Beck, 2008).

Medical Surgical Nurses: nurses that provide nursing care to adult patients with medical conditions or surgical conditions. For purposes of this research, this includes those nurses in the acute care setting.

Ethical climate: the collective values and behaviors considered to be acceptable or unacceptable within an organization. These values, beliefs, and behaviors are not formally taught or discussed (Mallory et al., 2009).

Futility of care: continuing to provide aggressive treatment when the patient is terminal and the interventions do not benefit the patient. These situations most often occur at the end of life (Hamrick & Blackhall, 2007)

CHAPTER TWO: REVIEW OF THE LITERATURE

Ethics and moral issues have been an important part of nursing practice throughout its evolution. The nature of caring for human beings in difficult, vulnerable, dangerous, and tumultuous situations brings many ethical situations to light. For decades nursing has struggled to define what it means to be ethical and a code of ethics is at the center of the profession.

The American Nurses Association (ANA) devised the *Code of Ethics for Nurses with Interpretive Statements* as a tool to guide nurses in evaluating oneself and practice (Fowler, 2010). However, a multitude of ethical constructs have been dissected and studied. Ethics is defined as a public set of rules and or values such as the *Code of Ethics*; whereas, morals are defined as a personal set of values or principles (Jameton, 1984). Nurses are constantly struggling to determine what their moral values are and process situations that challenge their sense of morality. While the primary care responsibility is to the patient, nurses are constantly being bombarded by demands from numerous stakeholders like families, physician, managers, administrators, and others. The challenge nurses confront frequently is demonstrated in Provision 2 of the *Code*: “The nurse’s primary commitment is to the patient, whether an individual, family, group or community” (Fowler, 2010, p. 11). In fact, this most recently published *Code* discusses that while this is a nurses’ primary obligation, they often have other conflicting or competing obligations not only to the patient but also to the organization, other clinicians, as well as the nursing profession.

Out of the analysis of ethical debates and concepts emerged the concept of moral distress, which is defined as when “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). These situations describe an individual who knows the ethical decision to make but does not make that choice due to organizational policy, legal issues, medical hierarchy, lack of time, or family dynamics. The result for the individual is psychological disequilibrium along with powerlessness and guilt (Corley et al., 2001). The expansion of this concept reflects the ongoing challenges faces by a multitude of stakeholders within health care.

In 1993, Jameton further delineated two forms of moral distress: initial and reactive. Initial distress occurs when an individual experiences anxiety, anger, and frustration when their values conflict with others or the institution (Corley et al., 2001). Reactive stress occurs because the person did not act on the initial distress, which escalates the psychological strain. The external conflict impacts the internal struggle in considering the ethical decisions.

The theory of moral distress was proposed by Corley in 2002 and was described as having an internal and an external context. The internal context is the psychological effect and the external context is focused on the work environment. Nursing has been described as a moral profession with nurses as moral agents. The theory proposed eight moral concepts used to describe moral distress throughout the literature. How these concepts act and interact with one another can lead to moral distress or moral intent to act. Moral distress can have an impact on three levels: the patient, the nurse, and the organization (Corley, 2002).

Moral distress has been found to have a negative impact on patients, nurses, and organizations. In an attempt to process their anxiety, grief, or frustrations, nurses may avoid or distance themselves from patients. Ultimately, this impacts the ability of the nurse to act as a patient advocate resulting in inadequate pain management, inadequate care, and longer hospital stays (Corley, 2002). From a personal perspective, experiencing moral distress can lead to increased suffering and psychological turmoil. Nurses have reported nightmares where they have experienced what the patient had endured (Zuzelo, 2007). Suffering can lead to burnout, loss of job satisfaction, and ultimately turnover. Some nurses have not only left their positions but have left nursing altogether (Corley, 2002). On an organizational level, moral distress can lead to high turnover of nursing staff, lower patient satisfaction, and decreases in the quality of care. This can have devastating impacts on the financial status and reputation of the organization. Eventually these ongoing issues can lead to challenges with regulatory and accreditation agencies (Corley, 2002; Zuzelo, 2007).

After analyzing studies of stress and turnover, Corley, Elswick, Gorman, and Clor (2001) developed an instrument titled the Moral Distress Scale (MDS). These researchers used the concept of moral distress, role conflict, and theory of values and value systems to derive a tool to measure moral distress. The scale was determined to be valid and reliable, but the factors focused on end-of-life issues and the experiences of nursing in the intensive care setting. There were initially 30 items on the scale that were categorized into three factors: individual responsibility, actions not in the patient's best interest, and deception (Corley et al., 2001). The MDS was modified to include 38 items expanded to include pain management, incompetent care by nurses and other nursing

personnel, and managed care (Corley, 2002). A 0 - 6 Likert scale can be used to measure two dimensions, which include the intensity of moral distress and the frequency.

Originally, when Corley et al. (2001) was in the process of developing the scale, the investigators distributed the MDS to a group of critical care nurses and occupational health nurses. The occupational health nurses did not report moral distress in their practice whereas the critical care nurses reported experiencing moderate to high levels of moral distress.

Moral Distress in Specialty Care Settings

The percentage of deaths occurring in intensive care units in hospital setting is around 20%; and while the ICU is thought of as a place for lifesaving interventions, it is also a place where those interventions are unsuccessful and even considered futile (Zomorodi & Lynn, 2010). “The majority of research on moral distress has been conducted with nurses working in acute care adult inpatient settings – especially critical care areas” (Cavaliere, Daly, Dowling, & Montgomery, 2010, p. 146). Nurses are perceived to assist life saving measures but often feel conflict when they have to transition to providing end-of-life interventions and support. The values, attitudes, and experiences of these specialty nurses can impact levels of moral distress and moral conflict.

Studies using the MDS as well as qualitative methods have identified themes of moral distress among critical care nurses. The predominant conflict centers around overly aggressive medical treatment thought not to be in the patient’s best interest (Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Rogers, et al., 2008). Metzler and Huckbay (2004) conducted a study to specifically evaluate if moral distress involving

futility of care situations resulted in emotional exhaustion. Certainly, intensive care units have more aggressive options for treatments than medical surgical floors; but there are situations where unnecessary treatments, procedures, and interventions are employed on a multitude of units.

Several recent studies have focused on the neonatal intensive care units. This is a highly difficult and emotionally charged place for not only nurses but parents and families as well. Advances in technology and pharmaceuticals have significantly impacted this population and the interventions of the health care team. Younger, smaller, and more complex babies are surviving who historically were not viable. This introduces new and different ethical dilemmas for nurses particularly when they must conduct painful procedures or conduct futile lifesaving interventions (Kain, 2007). The results of the research findings were similar compared to critical care nurses. Aggressive and futile care without benefit to the patient exhibited the most frequent and intense levels of moral distress (Cavaliere et al., 2010).

Unlike other moral distress studies, Cavalier et al.'s (2010) study identified correlations between demographic variables and levels of moral distress. There were four demographic characteristics that predicted moral distress. These included those who had previously considered leaving a previous position because of moral distress, nurses who had changed their approach to patient care, nurses who were not spiritual, and those who were currently considering leaving their position (Cavaliere et al., 2010). This study was conducted in a neonatal ICU so it is unclear if the findings were specific to this population of nurses. However, it is imperative for research studies to determine if there are demographics that may help determine intensity and frequency of moral distress.

Moral Distress in Other Disciplines

Moral distress is not just reserved for members of the nursing profession; other health care professionals encounter similar difficult situations. Moral distress has been studied in respiratory care practitioners because they often encounter comparable stressors. They also play an integral role in care of the critically ill and those at the end of life. While the MDS was utilized, the purpose of the study was to modify it specifically for respiratory care providers (Schwenzer & Wang, 2006).

Hamrick and Blackhall (2007) conducted a study to explore the relationship between moral distress in registered nurses as well as physicians. The study indicated that physicians experience moral distress too, particularly when they feel the pressure to continue unnecessary, aggressive treatment. The study highlights the differences between the professions with nurses perceived as experiencing less collaboration and more negative ethical climates (Hamrick & Blackhall, 2007). Levels of moral distress have also been identified among medical students. Interestingly, moral distress occurred more frequently for female medical students compared to males (Wiggleton et al., 2010).

Conducting studies in other disciplines is an important step in addressing profession-specific related issues as well as opening up the dialogue for how moral distress can impact the interactions between members of the care team. Moral distress has also been studied in nurse practitioners in the primary care setting, clinical pharmacists, and physical therapists (Carpenter, n.d.; Laabs, 2005; Sporrang, Hoglund, & Arnetz, 2006). While there are areas of ethical conflict identified in these clinicians, the same level of moral distress is not detected as with bedside clinicians in more acute care settings.

Moral Distress Related to Ethical Climate

Moral distress has been correlated to the ethical climate of the organization in multiple studies. This is not surprising regarding the concept of moral distress as knowing the right thing to do but not being able to do it due to a multitude of constraints. In order to understand the relationship between moral distress and the ethical climate, one must evaluate the concept of ethical climates. Ethical climate of an organization is defined as the collective ethical values, beliefs, and behaviors within the institution. These behaviors are often informal but exhibited, expected, and socialized (Mallory et al., 2009). The ethical climate therefore will impact the work environment for nurses. The type of ethical environment and organizational values will become evident in how the organization treat patients and staff establish goals and handle conflicts (Corley et al., 2005). “The ethical climate provides a context for professional nursing practice that in turn contributes to patient and nurse outcomes, including patient safety and the recruitment and retention of nurses” (Pauly, et al., 2009, p. 562).

Several studies have administered the MDS also included assessments of ethical climate or workplace environments. One study found that moral distress intensity levels were correlated to the ethical work environment but did not correlate with the frequency of moral distress (Corley et al., 2005). Another study focused on the relationship between perceptions of the ethical climate and moral distress. The findings of this research also indicated that intensity and frequency of moral distress were correlated to the ethical climate of the organization except in the peer related factors of the scale (Pauly et al., 2009).

The discussion for the ethical climate of the organization is important as a correlated factor and especially relative to the design of this study. A majority of studies have been conducted in the intensive care areas or have included both medical surgical registered nurses and specialty areas. One study specifically focused on medical surgical nurses within the same organization but was also a two hospital system (Rice et al., 2008). Another study conducted within one hospital included nurses from intensive care units as well as medical surgical units (Zuzelo, 2007). Only one large randomized study has been done on nurses practicing in acute care settings in Canada and British Columbia (Pauly et al., 2009). Apparently, this was the first attempt “to obtain a random sample and given the overall sample size is among the largest to date” (Pauly et al., 2009, p. 569).

These studies were important to the design because two of the three were completed within the same organization. As noted previously in the review of the literature, researchers indicated that there was a correlation between the ethical climate and the levels of moral distress. This could impact the ability to generalize this research to the population in question of medical surgical nurses. As for the large randomized study conducted on acute care nurses, the research was conducted in Canada under a different health care model. In addition, nurses that worked in maternity, psychiatry, and outpatient were included in the study. This design limits the generalizability due to the nature of the factors included in the MDS that do not apply to those specialty areas (Zuzelo, 2009).

This purpose of this research was to measure moral distress in a large sample of medical surgical nurses among different organizational settings. This will contribute to

the body of knowledge regarding levels of distress specifically among medical surgical nurses. The impact of the organizational ethical climate will not be a factor in this study due to the sample size being randomized from a variety of organizations. A multitude of findings of numerous studies indicated nurses experience moderate levels of moral distress. Factors triggering the highest levels of moral distress have centered on competency, nurse staffing levels, and aggressive care that is not in the best interest of the patient (Pauly et al., 2009). This study evaluated the frequency and intensity of moral distress for medical surgical nurses as well as the impact of demographic characteristics.

CHAPTER THREE: METHODOLOGY

Research Design

This study was a mixed method project to determine the frequency and intensity of moral distress among registered nurses in medical surgical units. The survey responses on the MDS were analyzed to determine if there were a correlation between demographics and the frequency and intensity levels of moral distress factors. The qualitative descriptions were analyzed using phenomenological methods to evaluate themes in nurses' experiences of moral distress.

Setting

The survey was administered via U.S. Postal Service mail in January 2011. A self-addressed stamped envelope was included to facilitate participation. Respondents had 4 weeks to return the survey to the principle investigator. A post card reminder was sent 2 weeks after the initial mailing to encourage participation and remind nurses of the study. A limitation of mailed surveys is they typically do not have a high response rate. However, the benefit of this method versus an Internet-based survey is a more diverse sample. Internet-based surveys often result in a narrower sample of people who are comfortable with computers and have access to technology. Another limitation of mailed surveys is that people may throw away the mailing.

Population and Sample

The sample for the study was a random selection of 1,000 registered nurses (RNs) throughout the state of North Carolina. The inclusion criteria included RNs currently working in acute care medical surgical settings from a variety of institutional, geographic,

and socioeconomic settings. The sample population was limited to those that are current residents of the state and did not include those licensed in North Carolina but living elsewhere.

Those excluded from the study included pediatric and neonatal, intensive care, long term care, office based, and home care nurses. In addition, those in the acute care setting that work in psychiatry, outpatient, and maternity were also excluded. Nurses currently not working in an acute care setting were excluded, i.e., retired or on maternity leave. A question was added to the demographic questionnaire to identify managers/directors. Those that answered yes were excluded from the study.

The North Carolina Board of Nursing (NCBON) database was utilized to obtain the sample. Currently, nurses designate their specialty upon issuance of licensure; sampling had the potential to be skewed due to inaccurate self-classification. There is no standard definition for “medical surgical” nurses on the NCBON website. Sample size may have been limited due to the Board’s sorting capability within the medical surgical specialty.

Protection of Human Subjects

The study was approved by Western Carolina University’s Institutional Review Board (IRB) in December 2010. The survey was mailed to the random sample obtained from the North Carolina Board of Nursing. Explanation of the study accompanied each survey to provide rationale for the study and directions for completion and to describe how to protect the identification of respondents and maintain confidentiality. Contact information for Western Carolina University’s IRB was included in case the individual

had a question or concern. Respondents' completion of the survey implied informed consent to participate in the study.

Instruments

Every instrument was accompanied by a cover letter that introduced the purpose of the study (Appendix C). The letter included information about the researcher and Western Carolina University's IRB. The researcher's contact information was included in the event that the individual had questions or concerns. The letter contained instructions on how to complete the survey as well as how to return their responses via mail. The survey had three sections: demographic information, quantitative survey, and the qualitative questions.

The instrument used in this study to quantify levels of moral distress is the Moral Distress Scale (MDS) (Corley et al., 2001). The MDS was originally developed in 2001 as a 30-item scale. The scale is designed to measure two variables: intensity of moral distress and frequency of the situation in question. Both the intensity and the frequency are measured with 0 - 6 Likert Scale with 0 being no moral distress or no encounter and 6 being great moral distress or frequent encounters. The tool was then modified to 38 items as illustrated in Appendix A. Three factors or dimensions were identified in the factor analysis phase: individual responsibility, not in the patient's best interest, and deception. Within those three themes, Corley asked nurses to rank the level of intensity or frequency in situations like working with unsafe staffing levels, assisting the physician who in your opinion is providing incompetent care, following the family's wishes for patient care when you do not agree with them (Appendix A). The instrument was developed and tested in three stages: test-retest, known groups, and administration of the instrument to a

sample of 214 nurses (Corley et al., 2001). The researchers used factor analysis and reliability estimation to determine that the instrument was valid and reliable (Corley, 2001). Respondents were instructed to leave the item on the scale blank if the item was not applicable. Permission was requested and granted by Dr. Corley to use the MDS on October 31, 2010.

This survey contained three qualitative questions to allow participants to describe their experiences of moral distress. The intent was for this to provide a storytelling component to elicit narratives with rich descriptions unavailable in quantitative strategies. These descriptions enhanced the results from the survey. The three questions administered were as follows:

Please describe the following situations in the areas provided below. Any details about values, beliefs, and perceptions are welcome and appreciated. Please do not use names to ensure confidentiality.

- Please describe a situation in which you experienced moral distress working in a medical surgical unit.
- Please describe how the moral distress situation impacted you personally. This may include physically, emotionally, or spiritually.
- Please describe how the situation impacted those around you. This may include the patient, the family, colleagues, manager, organization, etc.

Data collection and Field Procedures

The anonymity of all respondents was protected through a random numbering of the surveys. No names were included. Any name enclosed caused the survey to be excluded. The surveys were numbered in the order they arrived via mail. Each page of

the individual survey response was labeled with a designated number. Data entry into Excel was conducted by the principle investigator. The demographic data was entered into an Excel worksheet according to the randomly numbered survey response.

Demographic elements were coded numerically to allow for analysis of correlations with moral distress intensity and frequency. The quantitative responses had two sections of data: frequency of moral distress and intensity of moral distress. The response's number along with the Likert rankings, were entered into a separate Excel worksheet.

The qualitative responses were transcribed by the principle investigator. The responses to Question 1 were entered into an Excel spreadsheet; then Questions 2 and 3 were transcribed onto other worksheets. Using content analysis open coding procedures, the responses were analyzed for themes. The researcher utilized the selective approach to allow themes to be highlighted and phrases were noted that described the moral distress experience (Polit & Beck, 2008). The responses were organized according to emerging themes. Each highlighted item with descriptions from respondents substantiated the theme.

Data Analysis

Collection of data from the quantitative section of the survey was analyzed by the researcher with the assistance of an industrial engineer with extensive background in statistical analysis and quality control. The mean and standard deviation was determined for the frequency and intensity for each individual element. In addition, the overall median was calculated for the frequency and intensity of moral distress.

Demographic data were analyzed to determine if there were a correlation between levels of moral distress and the demographic factors. The correlation analysis evaluated

if there were a relationship between the demographics and the frequency of moral distress.

The responses from the questions regarding moral distress experience were analyzed for similar themes as discussed in the data collection section. The responses were typed and entered into an Excel database with each question occupying a single worksheet. This gave the researcher the ability to evaluate the themes of the questions independently and then determine overall themes for all of the questions. The answers were reviewed multiple times in order to reveal the themes. The themes and their associated responses were organized and aggregated. In order to confirm the identification of themes, the data was evaluated for themes by individual knowledgeable of moral distress research and then reviewed a third time by the thesis chair.

Triangulation provides additional trustworthiness of data analysis.

Limitations

A limitation of this study was the sample size. While the researcher would have preferred to obtain a larger sample size, there were financial and time restrictions. The low response rates of mailed surveys had the potential to skew the results of the study. While post cards were utilized to increase the response rate, an additional mailing with the instrument might have been more beneficial.

Another challenge was the quality of the demographic information submitted to the North Carolina Board of Nursing (NCBON). There are no specific guidelines for how to identify disciplines, which has the potential to leave out certain individuals. That information may have distorted the specificity of the bedside medical surgical population desired in this study.

Another limitation was the quality of the qualitative questions. There are no standard qualitative questions used to evaluate moral distress. The ones utilized in this study may not have fully captured related concepts. Another challenge is that respondents may not have been interested in sharing their experiences particularly if they were concerned about the time needed to complete the instrument. Nurse may have chosen not to complete the qualitative section because recalling vivid distressing situations may have made them uncomfortable and caused additional stress.

CHAPTER FOUR: RESULTS

Sample Characteristics

One thousand surveys were sent to medical surgical nurses who currently reside in the state of North Carolina. Of the 1,000 in the sample, 21 were returned to sender and 100 people responded to the survey for a 10.2% return rate. Five surveys were received after the due date and were excluded according to the study protocol. All of the 100 respondents completed at least some portions of the demographic section and moral distress scale; of the demographic questions, only the geography question had some blank answers. Not all questions of the MDS scale were answered by every respondent; several of the questions had both intensity and frequency ratings left blank or had the intensity or frequency left blank. If they were not completed, the researcher entered them into the database as such. Of the 100 respondents, 18 identified themselves as managers/directors; therefore 82% of the respondents were bed-side clinicians. Those self-identified as a manager/director were excluded from the statistical evaluation of the MDS, demographic responses, and qualitative analysis. This was to ensure that the sample consisted of those who provide direct patient care.

For the qualitative questions, of the 82 responses (excluding managers/directors), 57 (70%) answered the first question, which asked for them to describe a morally distressing situation. Fifty six people (68%) answered the second question about how moral distress impacted them emotionally, physically or spiritually; 51 (62%) answered how moral distress impacted those around them. Several respondents gave multiple

examples within a single question; this was most commonly found in the first question. Some people answered portions of each question with one response.

The demographics of the sample found in Appendix D indicated that 98% of the sample was female. The most common geographical location was an urban setting. Forty nine percent of the respondents reported their highest degree as a Bachelor of Science in Nursing. The next most frequent was an associate's degree. Few had a master's or higher. The age group found most often was 31-40 years old. Thirty three percent of the participants had been a nurse for 5 years or less. The type of hospital where most currently work was in the community setting. An overwhelming percentage of nurses in the study worked on a unit that had a mix of medical and surgical patients rather than one type of patient.

Major Findings in the Quantitative Data

Analysis of the quantitative data was conducted within the Excel program. Pearson's correlation coefficient was used to determine if there was a relationship between each of the demographic factors with both intensity and frequency for the 38 questions for a p value < 0.05 (Appendix E). Initially, there were multiple statistically significant correlations with $p < 0.05$ and therefore a stricter level of significance $p < 0.01$ was used. All relationships with the $p < 0.01$ identified a correlation with intensity and either age or experience and were placed in Appendix F in the order of higher to lower absolute value. There were no correlations determined in this study using the significance of $p < 0.01$ between the frequency of moral distress and demographics.

The highest absolute correlation value occurred between the intensity of moral distress and the experience level of nurse in situations described in Question 27, "Not

being able to offer treatment because the costs will not be covered.” Less experienced nurses had higher levels of moral distress ($r = -0.298, p = 0.007$). The next highest absolute r value occurred in situations such as Question 14, “Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay;” younger nurses experienced greater moral distress ($r = -0.295, p = 0.007$).

Question 4, “Assist a physician who performs a test or treatment without informed consent,” had a correlation that was positive. Older nurses identified this situation as causing more intense levels of moral distress ($r = 0.291, p = 0.008$).

Question 10, “Let medical students perform painful procedures on patients solely to increase their skill” and Question 33, “Work with nursing assistants who are not as competent as patient care requires” both had the same r value and p value but different relationships to intensity ($r = -0.285, p = 0.009$). When medical students practice on patients, younger nurses experienced greater moral distress. Less experienced nurses felt more moral distress when working with nursing assistants they do not think have the competence to care for the patient. This same relationship between intensity and experience occurred in circumstances described in Question 8, “Carry out a work assignment in which I do not feel professionally competent,” ($r = -0.284, p = 0.010$).

The lowest absolute correlation value but still statistically significant indicated a relationship between intensity and experience and Question 14, “Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay” ($r = -0.261, p = 0.004$). This was the only factor that had two demographic correlations (age and experience). Younger and less experienced nurses reported higher levels of moral distress with this type of encounter.

The mean and standard deviation were calculated for both intensity and frequency for each of the 38 questions (Appendix G). The mean for all intensity responses and frequency responses were calculated. The mean for intensity was 2.17 and the frequency was 1.32. Overall, medical surgical nurses identified higher levels of moral distress on the MDS scale than the frequency by which they occur.

For the intensity responses, the most intense levels of moral distress were identified with circumstances of staffing levels nurses considered as unsafe ($M=3.81$, SD 2.26) (Appendix G). The other situations that caused intense feelings of moral distress centered around incompetent nurses ($M=3.46$, SD 2.12), nursing assistants ($M=3.28$, SD 2.20) and physicians ($M=3.20$, SD 2.38). Two other factors related to futility had a mean greater than 3 and had higher levels of moral distress. Higher levels of moral distress were found when extensive life-saving actions are initiated and the nurse thinks it only prolongs death ($M=3.45$, SD 2.26) and when the family's wishes to continue life support are followed even though it is not in the best interest of the patient ($M=3.10$, SD 2.35).

The situations that respondents identified as causing less intensity of moral distress included: assisting physicians who are practicing procedures on a patient after CPR has been unsuccessful ($M=1.00$, SD 2.06), giving medications intravenously during a Code with no compressions or intubation ($M=1.10$, SD 2.00), and responding to a patient's request for assistance with suicide when patient has a poor prognosis ($M=1.15$, SD 2.24).

Overall, the frequency of morally distressing situations was lower than intensity. The mean of frequency for each of the 38 items was never greater than 3. The factor that was the most frequently encountered was working in unsafe staffing levels ($M=2.93$,

SD 2.18). Incompetence of nurses ($M=2.67$, SD 1.91) and nursing assistants ($M=2.60$, SD 2.15) were also frequent occurrences (Appendix E). The factor that occurred with the least amount of frequency was when a nurse is expected to assist a physician who is practicing procedures on a patient after cardiopulmonary resuscitation (CPR) has been unsuccessful ($M=0.17$, SD 0.68). The *SD* of 0.68 indicates that there is less variation between respondents to this question. The other least frequent situation was the expectation to respond to a patient's request for assistance with suicide when patient has a poor prognosis ($M=0.18$, SD 0.79). Several other factors did not occur often, which included: carrying out orders or institutional policies to discontinue treatment because the patient can no longer pay ($M=0.32$, SD 0.90) and assisting a physician who performs a test or treatment without informed consent ($M=0.40$, SD 0.72).

ANOVA for a single factor was calculated for intensity and frequency of all 38 questions. This was conducted two ways to evaluate the variance between questions as well as the variance between respondents. Both were statistically significant as having variance indicating that study participants were not picking the same Likert value for every question. The variance between respondents also indicates that survey responses were not copied.

Major Findings in the Qualitative Data

Content analysis methods were used to analyze themes of the qualitative data. Each analysis was applied to each individual question. Both themes and subthemes emerged from the body of responses. In order to give confirmatory evidence of trustworthiness, the themes were categorized and then aggregated to determine those that were the most consistently identified across all three questions.

Nurses identified inadequate staffing as a morally distressing situation.

Inadequate staffing impacts the nurses' ability to meet the patients' needs. These needs are often related to the acuity of the patient as well as the number of patients. In this study, participants described inadequate staffing not only in terms of numbers of nurses and support staff and patient acuity but also included concern regarding the skill level of other nurses. One moving response from a participant was as follows:

One night shift (7p-7a), staffing was me and two new grad RNs, just off orientation and no CNA, no charge nurse. We had 21 patients on a medical floor. Many [patients] incontinent, confused. Nursing supervisor called but would not get us any more staffing. Patients did not receive adequate care. It was a nightmare!

Other staffing responses were focused on the impact of inadequate numbers of staff on patient care rather than on individual nurses' skill.

Another overarching theme was the lack of disclosure and informed consent.

Nurses expressed great concern when patients and families were not informed about care and treatment options. There were descriptions of ineffective communication and/or explanation to the patient and/or family about the care, treatment and services including risks, benefits, and alternatives. A nurse in the survey gave examples of this type of incident:

Once had a doctor who wrote No Code Orders for all his patients. As I was describing the armband indicators – the patient had no idea she was a no code and didn't want to be. I called the doc and he said she couldn't be his patient. [I had] to discharge her she was sick! I informed her and discharged her.

Descriptions of this theme also included the breakdown in communication between providers and patient/families, lack of disclosure about the patient's condition, physicians not giving the patient and/or family the option of palliative care or hospice, etc. This theme was particularly prominent in situations at the end of life.

The other main theme in morally distressing situations revolved around futility. Futility is thought of as providing care that is unnecessary and ultimately does not change the patient's outcome. Nurses expressed feelings of guilt and frustration when procedures, tests, and treatments were done on a patient who was expected to die. The nurse described incidents as follows:

Frequent episodes where the patient was coded over and over again because no one addressed patient's situation in a realistic way so that families could make patient a No Code. Very frustrated because I could tell that the patient was gone but could not go out and talk to family myself about what was realistic.

The descriptions of incidences of moral distress demonstrated their impact on the nurses emotionally, physically, and spiritually. Overwhelmingly, nurses described being frustrated, angry, sad, upset, guilty, and emotionally drained and exhausted. One nurse described the impact in the following way:

Was emotionally distressing because I was doing all in my power to intervene on a situation I knew would not end good for the patient. But I had no way to convey this to the MD where he would listen and give orders to intervene. Some physicians don't want to "be bothered" with "this patient just doesn't look right or is acting different" without specific objective symptoms. Also distressing with

family members saying "Do Something!" When you're doing all you can do in your scope of practice.

Nurses described the impact of the situations upon them physically, such as being tired/exhausted, feeling how “wrong the issue is in the pit of your stomach”/”sick to your stomach”, loss of sleep/sleeplessness, and physical pain. One nurse described the impact physically:

It's hard to sleep sometimes wondering when will a patient die due to inadequate treatment of the patient due to the nurses' inexperience or short staffing.

I would feel physically sick to my stomach and request to change assignments for the next shift if possible. Sometimes I would even cry privately.

There were several other general themes on how moral distress impacted their family, leaving the unit/profession, and general feelings of being stressed. Leaving the unit/profession is also known as being burned out. Two scenarios were described by one participant:

Situation 1: I (in the last 2 weeks) wrote a 2 page letter to my supervisor regarding [being] pulled to acute care telemetry chronically for the last 4 months and am incompetent, I am (not just felt) to care for these patients and also [how] unfair it is to the patient. I also called the alert line. I am also looking at other jobs outside of nursing after 14.5 years (all but 3 years have been at this hospital).

Situation 2: I feel as if I am setup from the start of the day for failure in all their (hospital's) expectations of me. I often go without eating for 12 hours to get

everything done. I have cut hours to part time to try to deal with it better. I'm totally burned out.

The above quote was an example of how devastating moral distress is to nurses and how detrimental it is to organizations and the profession as a whole.

One of the most poignant and encompassing descriptions of how moral distress effected nurses in a multitude of ways, was found in this respondent's answer:

Too many times I have left work saying "at least I did not kill anyone" and that was the best I could say. Sometimes it is because the patients are so sick, sometimes it is because of the assignments. Physically I feel broken. My back, neck, knees and feet hurt all the time. Emotionally I feel like I am going to explode and spiritually I feel completely drained. Most of the time there is nothing left for my family, I have been on meds for depression and I think it has played a large part in my marriage failing.

Moral distress also was overwhelmingly found to impact their colleagues and co-workers. Respondents described colleagues also experiencing stress, anger, frustration, and sadness.

The whole unit felt the stress of caring for this patient. Morose mood. Depressing. We usually try to spread the emotional and spiritual burden of caring for those types of patients around. And some of us even refuse those patients at times if we may feel more emotionally vulnerable on days.

Nurses who participated in this study described various situations that caused moral distress including staffing, futility of care, and incompetent staff. There were

many revelations on how they were personally affected. These occurrences also impacted patients, families, organization and the nurses' own families.

CHAPTER FIVE: DISCUSSION

Study Limitations

Due to the low response rate of 10.2%, it is difficult to generalize the findings to all medical surgical nurses. The goal was to study a sample of bedside medical surgical nurses currently in practice. Although the sample was a randomized sample, there may have been medical surgical nurses who did not self-identify in registration with the North Carolina Board of Nursing and therefore were not part of the sampling process.

The low response rate may have been due to several factors. Participants had to complete five pages of information with the moral distress scale itself being three pages in length. There were several comments received written on the survey stating that it was long. In addition, the MDS scale format may have caused some confusion. The researcher did not alter the tool in any way because it had been found to be reliable and valid. There were headings on the table for the Likert scoring on the first page of the scale but not the subsequent pages. Several participants filled in these numbers on the additional pages to assist them with completing the scale accurately. Others might not have done so, and their accuracy is thus unknown.

There is also the possibility of the data being miskeyed during data entry. The data entry was reviewed multiple times to ensure accuracy. The researcher also chose survey responses at random to validate accurate data entry.

The lack of completion of the qualitative questions may be due to several reasons. The study cover letter indicated that a respondent could choose to fill out all of the survey or elect to participate in only one section. This may have contributed to the 20% drop in

the response rate on the qualitative section. Contributing factors may have been the length and time to fill out the survey. There is also the possibility that the survey made nurses uncomfortable recalling upsetting memories, and therefore they chose not to complete it. However, there were several respondents that expressed their thanks and gratitude for the survey being conducted.

Even though there was a low response rate and several limitations, the results of the study indicated that medical surgical nurses experienced moderate levels of moral distress in certain circumstances. Moderate levels of moral distress, indicated by a mean > 3 , was found only in the nurses' perception of the intensity of specific MDS factors, which included: inadequate staffing, incompetent staff and providers, and futility of care. Similar findings of moral distress in these areas have been identified in studies of critical care nurses and other clinicians. The results indicated that medical surgical nurses experienced moral distress with greater intensity than the frequency similar to other randomized studies (Pauly et al., 2009). The data outcomes did not support the hypothesis that overall medical surgical nurses experienced moderate levels and frequency of moral distress ($M = 2.17$, $M = 1.32$). However, they did experience moderate levels within certain factors.

The researcher hypothesized that there were no correlations between the demographic variables and the intensity and frequency of the 38 items in the MDS scale. Using a p value of < 0.01 , there were no correlations between the demographics and frequency with that level of significance. However, there were statistically significant correlations between the level of intensity of moral distress with age and experience.

Overwhelming, the data indicates that younger nurses and those with less experience had perceptions of higher levels of moral distress in certain situations.

Implications for Nurses and Nurse Leaders

Interestingly, inadequate staffing not only caused some of the most intense levels of moral distress but was also identified as happening with higher frequency. This is an important consideration for leaders in evaluating competency of nurses and nursing assistants. The Joint Commission states that ensuring staff competency is integral to patient safety; the purpose of competency assessment is to evaluate an individual's knowledge, ability, and skill (2011). Organizations should develop robust systems to accurately evaluate the competency of staff in relation to their role and needs of the patient population. Otherwise, leaders run the risk of burdening other staff members with incompetence and morally distressing situations. The correlation of younger nurses reporting more intense feelings of moral distress with nurses assistants who are not as competent as care requires ($r = -0.285, p = 0.009$) suggests several contributing factors: 1) nursing assistants may not be competent, 2) younger nurses have not developed the skill or knowledge to evaluate the competency of the nursing assistant, or 3) younger nurses have not developed the ability to delegate appropriately based upon the assistant's skill. Therefore, leaders must consider the unique make-up of their employees in evaluating their staff competency.

This results of the study revealed that inadequate staffing causes the most intense levels and frequency of moral distress. Descriptions from the qualitative responses also echo these findings. Balancing adequate numbers and skill of staff is a struggle for many managers, supervisors, and administrators. Determining patient acuity and staffing needs

is a challenge for leaders particularly because there are few valid and reliable tools (Brennan & Daly, 2009). As the reimbursement for care shrinks, organizations are faced with greater challenges of generating adequate funding for labor. However, the cost of nursing turnover due to burnout may inspire leaders to concentrate on decreasing morally distressing situations as a cost containment strategy (Pendry, 2007). Addressing inadequate staffing can not only improve clinical outcomes of patients but also reduce moral distress and retain valuable nurses (Storfjell et al., 2008).

The correlation studies between the demographic characteristics and the intensity of the 38 items predominantly indicated that age and experience play a significant role in the perception of moral distress. Younger nurses and those with less experience felt a greater intensity. This is vital information for nursing colleagues and leaders in changing the ethical climate and providing support for this cohort of nurses. Younger and less experienced nurses may not have developed the skills and capacity to cope with these difficult ethical circumstances. The use of ethics committees, focus groups, and open discussions about ethics may help nurses develop the ability to advocate for patients and manage moral distress.

The qualitative responses were extraordinary glimpses into the nurses' reality of ethical dilemmas. The distress engendered by lack of communication and poor or nonexistent disclosure of care options was a predominant theme. Inadequate staffing also contributed heavily to the nurses' perception of moral distress. Respondents described the significant impact not only on themselves but their colleagues as well as the patient and family. The emotional and physical well being of nurses was jeopardized when they

encountered these situations. Nurses openly described how they felt burned out and considered leaving units or the profession.

Recommendations for Practice

This study has implications for nurses and nurse leaders. Medical surgical nurses make up a large portion of the acute care staff in hospitals and care for a large number of the patient population. This study supported the hypothesis that medical surgical nurses experience moderate levels of moral distress in certain situations. As American Association of Critical Care Nurses (AACN) stated in their position statement, every nurse has a responsibility to recognize moral distress, act and address the situation, and utilize professional and institutional resources to reduce moral distress, develop skills like mentoring to decrease ethically distressing situations, and implement changes to improve the work environment (AACN, 2008). Nurses have an ethical responsibility to be an advocate for patients in these types of situations but also be an advocate for themselves and one another.

Employers have a responsibility to monitor moral distress within their organizations, analyze what contributes to the intensity, and educate staff on what constitutes moral distress. (AACN, 2008; Gutierrez, 2005; Pauly et al., 2009; Ruston, 2008). Some studies have shown success with multifaceted workshops that included informing nurses about moral distress factors, sharing experiences, brainstorming about solutions, obtaining feedback on implementation challenges, and educating nurses about self-care and signs of burnout (Beumer, 2008). It is essential for leaders to create support programs like employee assistance programs, end-of-life protocols, ethics committees, debriefings after stressful situations, and grief counseling (AACN, 2008; Bosek, 2009;

Ruston, 2008). Support programs can empower nurses and shift the culture of an organization towards a healthy ethical climate.

Results Related to Theory

The qualitative descriptions supported Corley's theory of moral distress as it relates to the impact on nurses and patients (Corley, 2002). In the theory, moral distress impacts three entities: the nurse, the patient and the organization. The responses reflected all three of these concepts. Nurses described how they were affected emotionally, physically and spiritually. Multiple instances recalled how these personal struggles led to burn out, resignation from their unit, and a choice to leave the nursing profession. There were also descriptions of the effect of morally distressing situations on patients. Ultimately, patients had to endure unnecessary suffering because the nurses did not feel empowered to advocate for them. Theorists or other researchers may consider adding the impact of moral distress on the patients' family and the nurses' family to the theoretical model, particularly because there were rich and poignant accounts of the effect of moral distress on these support systems.

Findings Related to Other Studies

The themes identified in this study were consistent with other qualitative studies of registered nurses. Zuzelo (2009) conducted a mixed method study of registered nurses, but they were not all medical surgical nurses. Similar themes such as concerns with inadequate staffing, the lack of communication about care options, and quality-of-life issues were identified in that study as well as this one (Zuzelo, 2009). One can conclude that situations of moral distress are consistent and similar throughout the nursing profession.

Comparing this study to another conducted on medical surgical patients showed variation in correlations with moral distress factors and demographics. Rice et al. (2008) found cumulative effects of moral distress on the medical surgical nurses in their study. However, their population contained oncology and transplant nurses. In that study, those with greater years of experience reported higher levels of moral distress; whereas, this study indicated that those who are younger and with less experience felt a greater intensity of moral distress. Another difference between the two is that their study was a convenience sample within one organization that was an acute tertiary care hospital; and this study was a randomized sample throughout the state of North Carolina.

The large randomized study in Canada and British Columbia had a higher mean for intensity than the study in this thesis (Pauly et al., 2009). Generally speaking, that study had higher levels of moral distress in each of their factors. However, inadequate staffing and lack of competency of nursing colleagues were found to have the most intense levels of moral distress in their study as well as this one (Pauly et al., 2009). Inadequate staff was also identified in both studies as happening with the most frequency. Pauly et al. (2009) had a larger sample and obtained a 22% response rate. Their sample also contained registered nurses from a multitude of disciplines including critical care and other specialty areas. Unlike the current study, in the Pauly et al. (2009) study, there were no correlations with demographic characteristics; and they also were evaluating levels of moral distress with ethical climates.

Recommendations for Future Studies

Further studies should be conducted on medical surgical populations to determine if the findings of this study can be replicated. This type of study would add to the body

of knowledge or may raise further questions about medical surgical nurses. These results possibly will reveal additional information about whether the MDS scale should be utilized on medical surgical nurses or if it needs to be tailored specifically to this population.

Future research should compare moral distress between critical care nurses and medical surgical nurses. This would help to identify if there are more needs in one population or the other and help leaders to design programs to support staff. Evaluating the demographic make-up of each of the populations may also be beneficial particularly as it relates to the age and experience level. This evidence may determine if there are larger numbers of less experienced and younger nurses entering the medical surgical population compared to critical care.

Additional studies should be conducted to provide valuable information in determining whether levels of moral distress are increasing and decreasing. This is especially important as the landscape of health care changes particularly with health care reform. Studies continue to show that clinicians across health care experience moral distress, but there is concern that moral distress is not decreasing despite awareness of the issue.

Continuing to study levels of moral distress is important, but it is also valuable to study what solutions and programs help to reduce it. Additional studies are needed to evaluate effective interventions across multiple types of nurses like Beumer's (2008) research of workshops conducted with staff in the critical care setting and end-of-life educational programs for nurses in the neonatal intensive care unit (Rogers, Babgi, &

Gomez, 2008). This may include measuring if programs are more effective in the medical surgical population compared with other specialties.

Conclusion

While this study indicated that overall medical surgical nurses experienced low levels of moral distress, the qualitative responses gave moving descriptions of how devastating moral distress can be to the patient, the nurse, organizations and families. The nursing and health care communities have a moral responsibility to alleviate and address these harmful situations. Given the aging patient population, growing numbers of uninsured, decreases in reimbursement, and the shortage of nurses, nurses and nurse leaders have an ethical responsibility to tackle moral distress. The health care industry cannot afford to continue to lose nurses to burnout; therefore, future studies are imperative in understanding moral distress and improving the ethical climate of organizations.

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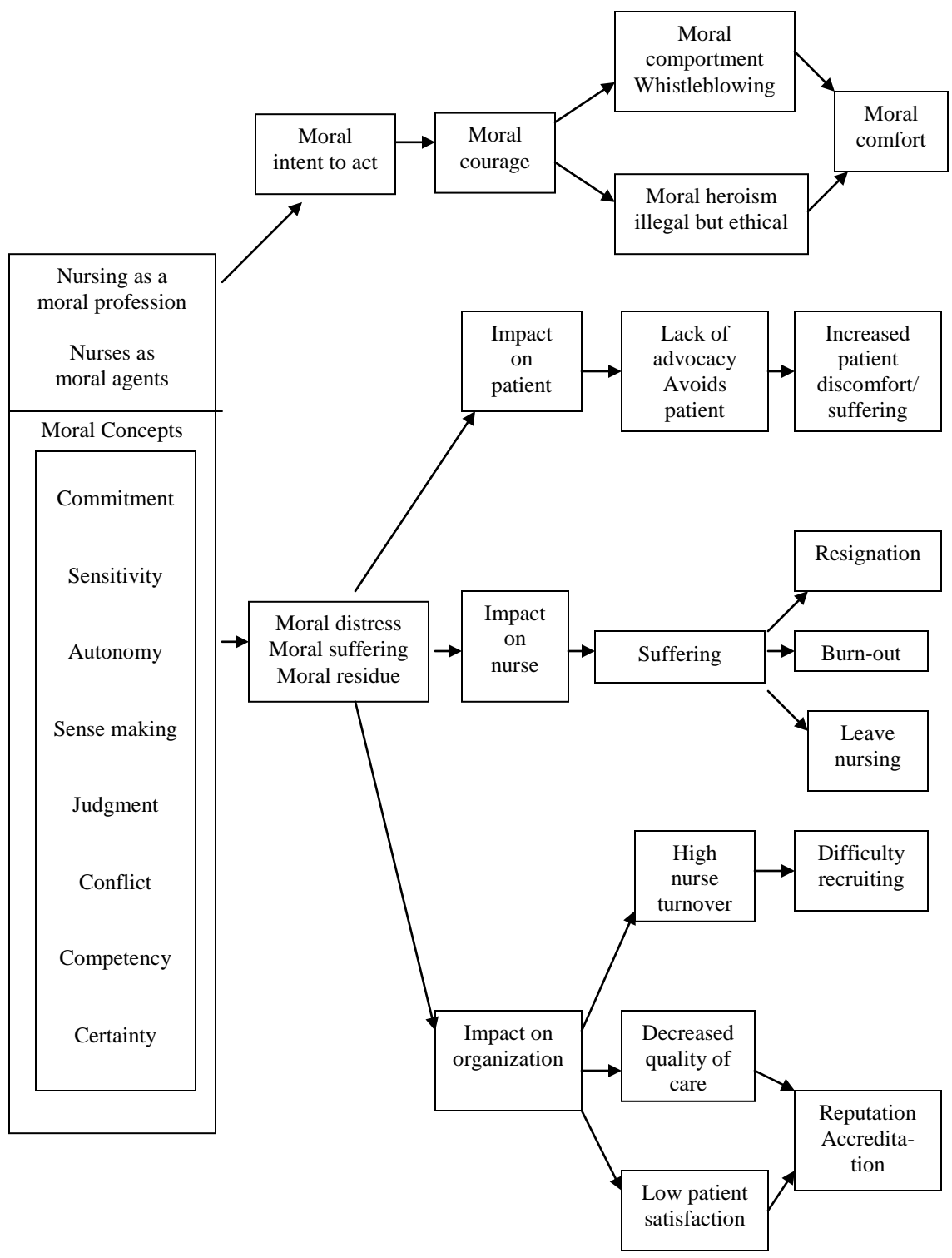
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37. Ask the patient's family about donating organs when the patient's death is inevitable													
38. Be required to care for patients I am not competent to care for.													

Appendix B

Figure 2: Model for Theory of Moral Distress



Appendix C

Figure 3: Study Letter Sent to Randomized Sample of Medical Surgical Nurses

Dear Medical Surgical Nurse:

Moral distress has been identified as an ethical issue nurses and other health care professionals face in their work. Nearly 80% of nurses have experienced moral distress and over 25% of nurses have left a previous position due to moral distress. Moral distress is defined as the painful or psychological distress caused by situations where you know the ethical decision or action to take but cannot carry it out due to institutional constraints. These constraints can include: lack of time, organizational policy, supervisory disinterest, medical power structure, or legal limitations.

The studies on moral distress have typically focused on nurses in critical care areas. However, medical surgical units are faced with increasing patient acuity, shorter lengths of stay, and staffing challenges. Therefore, it is imperative that research be conducted on moral distress in medical surgical nurses.

This is a request for your participation in a study of moral distress in medical surgical nurses. There are two portions of the survey. One is a tool to rank two items: the level of moral distress and the frequency of moral distress in your current position or role. The other section contains three questions to describe your experience, if any, of moral distress.

Participation in the survey is voluntary. If you choose to participate, one or both sections may be completed. Attached are the tools as well as instructions. I have also enclosed a self-addressed envelope. Please note that responding to the survey implies that you consent to participation in this research study.

Your response is greatly appreciated. I believe that this research is essential to the nursing profession and will help us to further understand the impact of moral distress on turnover, burnout, and nurses leaving the profession.

If you have any questions feel free to contact me at my information listed below or you may also contact Western Carolina University's Institutional Review Board. Please return your response by **February 1, 2011**.

I would be more than happy to share the results of this study with you. If you would like to receive them, please contact me by email at susieaft@gmail.com.

Thank you again for your participation,

Susie Aft RN, BSN, BA
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Research Administration
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Appendix D

Table 1: Demographic Makeup of Study Participants

Demographics	Numerator	Percentage
Gender		
1. Female	80	98%
2. Male	2	2%
Geographic Location		
1. Urban	31	39%
2. Suburban	24	30%
3. Rural	21	27%
4. Other	3	4%
Education		
1. Associate Degree	29	35%
2. Baccalaureate (nursing)	40	49%
3. Baccalaureate (other)	4	5%
4. Master's (nursing)	3	4%
5. Master's (other)	4	5%
6. Doctorate (nursing)	0	0%
7. Doctorate (other)	0	0%
8. Other	2	2%
Age		
1. 20-30	15	18%
2. 31-40	23	28%
3. 41-50	19	23%
4. 51-60	19	23%
5. 60+	6	7%
Years of Nursing Experience		
1. 0-5	27	33%
2. 5-10	11	13%
3. 10-20	22	27%
4. 20-30	14	17%
5. >30	8	10%
Type of Hospital		
1. Private not for profit	21	26%
2. Academic	19	23%
3. Community	27	33%
4. Private for profit	8	10%

5. Critical Access	1	1%
6. Other	6	7%
Type of Unit		
1. Medical	12	15%
2. Surgical	9	11%
3. Both	52	63%
4. Other	9	11%

Note: $n = 82$ except for the Geographic Section $n = 79$; numbering of each element within a factor was used in coding the data

Appendix E

Table 2: Correlation of MDS Factors to Demographic Factors with p value < 0.05

Question	Factor	Demographic Factor	r value	p value
1. Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit.	I	Ex	-0.221	0.046*
2. Follow the family's wishes to continue life support even though it is not in the best interest of the patient.	F	A	0.221	0.046*
4. Assist a physician who performs a test or treatment without informed consent.	I	A	0.291	0.008**
6. Ignore situations of suspected patient abuse by caregivers.	I	Ex	-0.273	0.012*
8. Carry out a work assignment in which I do not feel professionally competent.	I	A	-0.239	0.030*
8. Carry out a work assignment in which I do not feel professionally competent.	I	Ex	-0.224	0.044*
9. Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it.	I	Ed	-0.284	0.010**
10. Let medical students perform painful procedures on patients solely to increase their skill.	I	A	0.245	0.026*
10. Let medical students perform painful procedures on patients solely to increase their skill.	I	Ex	-0.285	0.009*
11. Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	I	A	-0.273	0.012*
11. Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	I	HT	-0.261	0.018*
14. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.	I	A	-0.295	0.007**
14. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.	I	Ex	-0.261	0.004**
15. Continue to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to 'pull the plug.'	I	Go	-0.230	0.037*
15. Continue to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to 'pull the plug.'	I	Ed	0.274	0.013*

19. Prepare an elderly man for surgery to have a gastrostomy tube put in, who is severely demented and a "No Code"	I	Go	-0.249	0.024*
	F	Go	-0.241	0.029*
20. Discharge a patient when he has reached the maximum length of stay based on the Diagnostic Related Group (DRG) although he has many teaching needs.	I	A	-0.286	0.009**
	I	Ex	-0.256	0.020*
23. Providing care that does not relieve the patient's suffering because the physician fears increasing a dose of pain medication will cause death.	I	Go	-0.246	0.026*
	I	HT	-0.245	0.026*
24. Give medications intravenously during a Code with no compressions or intubation.	F	Ge	-0.253	0.022*
	I	Ex	-0.256	0.020*
27. Not being able to offer treatment because the costs will not be covered.	I	A	-0.264	0.017*
	I	Ex	-0.298	0.007**
29. Respond to a patient's request for assistance with suicide when patient has a poor prognosis.	I	A	-0.256	0.020*
	I	Ex	-0.224	0.044*
	I	HT	-0.230	0.037*
31. Follow orders for pain medication even when the medicines prescribed do not control the pain.	I	Ex	-0.244	0.027*
	I	HT	-0.221	0.046*
33. Work with nursing assistants who are not as competent as patient care requires.	I	Age	-0.285	0.009**
	I	Ex	-0.248	0.025*

Note: I = Intensity; F = Frequency, Ex = Experience; A = Age; Ed = Education; HT = Hospital Type; Go = Geography; Ge = Gender; *r* value = Pearson's correlation coefficient negative values indicate correlation to answers that are lower numbers

* *p* value < .05

** *p* value < .01

Appendix F

Table 3: Correlation of MDS Factors to Demographic Factors in Order of Greatest Absolute Value

Question	Factor	Demographic Factor	<i>r</i> value	<i>p</i> value
27. Not being able to offer treatment because the costs will not be covered.	I	Ex	-0.298	0.007**
14. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.	I	A	-0.295	0.007**
4. Assist a physician who performs a test or treatment without informed consent.	I	A	0.291	0.008**
10. Let medical students perform painful procedures on patients solely to increase their skill.	I	A	-0.285	0.009**
33. Work with nursing assistants who are not as competent as patient care requires.	I	A	-0.285	0.009**
8. Carry out a work assignment in which I do not feel professionally competent.	I	Ex	-0.284	0.010**
14. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.	I	Ex	-0.261	0.004**

Note: I = Intensity; F = Frequency, Ex = Experience; A = Age; *r* value = Pearson's correlation coefficient; Correlations were listed in order of the greatest to least absolute *r* value

** *p* value < .01

Appendix G

Table 4: Mean and Standard Deviation for MDS Factors

Q	I		F	
	M	SD	M	SD
1. Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit.	2.60	2.00	2.27	1.78
2. Follow the family's wishes to continue life support even though it is not in the best interest of the patient	3.10	2.35	2.24	1.99
3. Carry out a physician's order for unnecessary tests and treatment.	2.76	2.02	2.63	2.10
4. Assist a physician who performs a test or treatment without informed consent.	1.37	2.15	0.40	0.72
5. Initiate extensive life-saving actions when I think it only prolongs death	3.45	2.26	2.55	1.98
6. Ignore situations of suspected patient abuse by caregivers.	1.28	2.12	0.51	1.01
7. Ignore situations in which patients have not been given adequate information to insure informed consent.	1.90	2.18	1.16	1.49
8. Carry out a work assignment in which I do not feel professionally competent.	2.83	2.30	1.43	1.56
9. Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it.	1.83	2.05	1.35	1.77
10. Let medical students perform painful procedures on patients solely to increase their skill.	1.55	2.13	0.71	1.25
11. Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful.	1.00	2.06	0.17	0.68
12. Carry out the physician's orders for necessary tests and treatment for terminally ill patients.	2.68	2.29	1.62	1.81

13. Work with levels of nurse staffing that I consider “unsafe.”	3.81	2.29	2.93	2.18
14. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.	1.33	2.19	0.32	0.90
15. Continue to participate in care for a hopelessly injured person who is being sustained on a ventilator, when no one will make a decision to ‘pull the plug.’	2.00	2.58	1.07	1.74
16. Observe without taking action when healthcare personnel do not respect the patient’s privacy.	2.15	2.08	1.31	1.59
17. Follow the physician’s order not to tell the patient the truth when he/she asks	1.79	2.35	0.77	1.36
18. Assist a physician who in your opinion is providing incompetent care	2.52	2.53	1.32	1.61
19. Prepare an elderly man for surgery to have a gastrostomy tube put in, who is severely demented and a “No Code”	2.83	2.42	1.70	1.81
20. Discharge a patient when he has reached the maximum length of stay based on the Diagnostic Related Group (DRG) although he has many teaching needs.	2.26	2.39	1.33	1.76
21. Provide better care for those who can afford to pay than those who cannot.	1.35	2.19	0.57	1.19
22. Follow the family’s request not to discuss death with a dying patient who asks about dying.	2.29	2.41	1.16	1.65
23. Providing care that does not relieve the patient’s suffering because the physician fears increasing a dose of pain medication will cause death.	2.76	2.51	1.66	1.83
24. Give medications intravenously during a Code with no compressions or intubation.	1.10	2.00	0.65	1.48
25. Follow the physician’s request not to discuss the code status with patient.	1.44	2.24	0.68	1.43

26. Follow the physician's request not to discuss Code status with the family when the patient becomes incompetent.	1.38	2.00	0.58	1.39
27. Not being able to offer treatment because the costs will not be covered.	1.53	2.24	0.66	1.35
28. Increase the dose of intravenous morphine for an unconscious patient that you believe will hasten the patient's death.	1.38	2.00	0.94	1.52
29. Respond to a patient's request for assistance with suicide when patient has a poor prognosis.	1.15	2.24	0.18	0.79
30. Follow the physician's request not to discuss death with a dying patient who asks about dying	1.58	2.36	0.50	1.21
31. Follow orders for pain medication even when the medicines prescribed do not control the pain.	2.68	2.25	2.21	1.95
32. Work with nurses who are not as competent as the patient care requires	3.46	2.12	2.67	1.91
33. Work with nursing assistants who are not as competent as patient care requires.	3.28	2.20	2.60	2.15
34. Work with non-licensed personnel who are not as competent as patient care requires.	2.14	2.38	1.51	2.12
35. Work with physicians who are not as competent as the patient care requires	3.20	2.38	1.85	1.87
36. Work with support personnel who are not as competent as the patient care requires.	2.56	2.37	1.65	2.00
37. Ask the patient's family about donating organs when the patient's death is inevitable.	1.36	2.00	0.91	1.06
38. Be required to care for patients I am not competent to care for.	2.59	2.51	1.50	1.50
Overall Mean	2.17		1.32	

Note: I = Intensity; F = Frequency, M = Mean, SD = Standard Deviation, Q = Question in Moral Distress Scale; M > 3 for intensity are in boldface; M > 2.5 for frequency are in boldface