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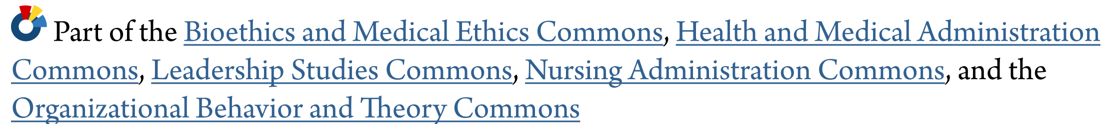
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CANADIAN NURSE LEADERS' EXPERIENCES WITH AND PERCEPTIONS OF MORAL DISTRESS: AN INTERPRETIVE DESCRIPTIVE STUDY

JODI-RAE KORTJE

A DISSERTATION

Submitted to the Ph.D. in Leadership and Change Program

of Antioch University

in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

July, 2016

This is to certify that the Dissertation entitled:

CANADIAN NURSE LEADERS' EXPERIENCES WITH AND PERCEPTIONS OF MORAL DISTRESS: AN INTERPRETIVE DESCRIPTIVE STUDY

prepared by

Jodi-rae Kortje

is approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Leadership and Change.

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Laurien Alexandre, Ph.D., Chair date

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Jon Wergin, Ph.D., Committee Member date

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Sally Thorne, Ph.D., Committee Member date

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I have been privileged with an extraordinary set of mentors, colleagues, friends and family who have supported and encouraged me in this academic pursuit and lifelong goal. First and foremost, I would like to acknowledge and thank the participants in my research study. Without their assistance and generosity, this research would not have been possible. I am humbled and inspired by their selfless dedication and commitment to excellence in patient care, leadership, and nursing practice.

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I also owe a sincere debt to my amazing dissertation committee—Dr. Jon Wergin and Dr. Sally Thorne—who offered their expertise and engaged me in critical reflection on practice, theory, and the 'so what' that is relevant to the application of nursing leadership practice. Their insightful reflections on my work enriched my thinking considerably, and I thank them for their mentorship and innumerable contributions to my growth as a scholar and leader. To mentors Dr. Paddy Rodney for her contributions on this dissertation and Martha Cloutier who unknowingly led me to the Antioch community.

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Dedication

To my mom, Sonia Mary Kortje~

You have taught me so much about life, love, and perseverance. It is because of your unconditional love and support that I am the person I am today. When I think back over the years and remember all the special things you have done for us as a family, I realize that you are not only a wonderful mom, you are also a unique and amazing woman. As a daughter, I am blessed to have you as a mother. As a nurse, I am privileged to have you as a colleague and mentor. Thank you for teaching me the art and science of nursing. Love you always and forever~ xoxo

Abstract

Moral distress in nursing has been studied across many care contexts, yet there is a paucity of research on the experience among health care leaders. The purpose of this study was to understand the experiences and perceptions of moral distress in nurse leaders. This study used an interpretive description approach interviewing 32 Canadian nurse leaders about their experiences and perceptions of moral distress within their role as a leader and nurse. A constant comparative and thematic analysis process revealed three thematic patterns: (a) leaders suffer moral distress in similar and different ways from their employees; (b) relationships matter in the midst of coping and emerging from moral distress; and (c) navigation through moral distress requires institutional, professional, and personal strategies. These patterns were important structural components in identifying the overarching metaphor of an ethical whirlwind that contextualized the experience as a vortex of constantly changing variables in dynamic interplay on a micro (patient/individual), meso (organizational), and macro (community) level. Findings were extracted from the participants' interpretations of their experiences and from the interpretation of the data that illuminated experiential issues of importance to nurse leaders in relation to moral distress. On the basis of study findings, resiliency, resourcefulness, and self-awareness assisted nursing leaders in navigating and meaning-making of their experiences. Recommendations for leadership practice, policy implications, and future research are suggested to help diminish conditions that produce moral distress. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/etd

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Chapter I: Introduction

Health care organizations rank among the most challenging and complex to manage (Drucker, 1993; Glouberman & Zimmerman, 2002). These challenges emanate from multi-dimensional competing variables including technology, financial/human resources, politics, globalization, a variety of stakeholders (e.g., patients, nurses, physicians, administration, and politicians), and an aging and increasingly demanding population. The level of complexity created by these variables and the constant and unpredictable change faced by these organizations is unprecedented.

As a registered nurse for over two decades, I have witnessed how operational and system challenges within the Canadian health system have intensified over the years, directly impacting not only the patient, but also the health care professional. The current system is fraught with constraints and inefficiencies that have created a complex landscape for patients as well as practitioners to navigate. The Health Council of Canada (2013) acknowledged this situation in its report on the condition of the Canadian health system, following the government's (federal/provincial/territorial) adoption of two significant health accords: The *First Ministers' Accord on Health Care Renewal* (Health Canada, 2003) and the subsequent *10-Year Plan to Strengthen Healthcare* (Health Canada, 2004). The Health Council's report noted that while health care has evolved, efforts to reform the health care system through the strategies outlined in these accords have not kept pace with the changing needs of Canadians. Consequently, Canada's overall health care performance has fallen behind several other high-income countries, with few notable improvements on measures of patient care and health outcomes. The Health Council asserted "none of these changes [outlined in the accords] have transformed Canada's health

system into a high-performing one, and health disparities and inequities continue to persist across the country" (Health Council of Canada, 2013, p. 4).

Health care professionals are intimately aware of the significant system challenges that make up the Canadian health care system. As an example, on any given day, Canada's emergency departments (EDs) epitomize how individuals can and do experience health disparities and inequities in the current health care system. EDs are intense high-velocity areas where patients arrive continuously with a variety of presentations. Patient concerns range from the very minor, such as an abrasion or sore throat, to life-threatening presentations, such as a motor vehicle crash or myocardial infarction. For many, the ED has become the main gateway to the Canadian health care system as a result of multi-dimensional organizational problems within the community and primary care service systems. These problems include the following:

- lack of primary health care providers (e.g., general practitioners and nurses);
- limited access and increased wait times for patient care;
- lack of and timely delivery of community and home care services;
- lack of access to an appropriate continuum of residential care services with a corresponding enhanced scope of practice required for care (e.g., management of Influenza/Norwalk outbreaks and aggressive patients);
- acute care capacity within hospitals;
- a rising burden of chronic disease and disability;
- limited mental health and substance services and capacity for acute illness; and
- budgetary constraints effecting service delivery (British Columbia Ministry of Health, 2013; Fraser Health Authority, 2014; Health Council of Canada, 2013; Romanow, 2003).

As the health system has become more restrictive and difficult to navigate, the ED has become a pressure valve for the entire health system where “the lack of acute-care beds in Canada means that most hospitals frequently operate at unsustainable occupancy rates of higher than 95%, a level at which regular bed shortages, periodic bed crises, and hospital overcrowding are inevitable” (Affleck, Parks, Drummond, Rowe, & Ovens, 2013, p. 363). Unfortunately, the disparities experienced by the patient and the operational pressures within the system have fuelled ethical concerns within the EDs and other workplaces directly affecting those who work within the health care system.

In the current health care setting within Canada and worldwide, there is a continuous presence of ethical concerns and challenges in the delivery of health care where institutional and organizational ethics have become increasingly more relevant. The tensions created by differences in organizational, individual, and professional values are visible when nurses and other health care providers grapple with ways to operationalize organizational goals that meet the patient’s best interests without violating personal and professional values. When the nurse or health care provider can not navigate between these intersecting values, *moral distress* occurs, a concept introduced within nursing ethics over thirty years ago.

The philosopher, Andrew Jameton (1984, 1993) was first credited with introducing the term *moral distress* as a concept within the scholarship body. He defined moral distress as occurring when “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (1984, p. 6).

Purpose and Rationale of the Study

The purpose of this interpretive descriptive (ID) study is to understand the experiences and perceptions of moral distress in nurse leaders as they navigate through morally troubling

situations within the Canadian health care system. The intent is to gain a deeper contextual understanding of moral distress within leadership by capturing firsthand accounts of nurse leaders' experiences. This is accomplished by listening to and analyzing and interpreting the stories shared by a variety of nurse leaders. New insights emerged from the experiences and perceptions shared by research participants. This research creates awareness of the experience of moral distress in nurse leaders, supplements gaps in knowledge on leader specific recommendations for mitigation, and expands on the understanding of the concept by examining the leadership role.

Ethical and moral issues have been present in health care and the profession of nursing for decades. What sets this occupational stressor apart from others (e.g., burnout, compassion fatigue, vicarious trauma) and makes it unique is that moral distress specifically refers to the phenomenon of stress associated with ethical dimensions of health care practice (Pauly, Varcoe, Storch, & Newton, 2009). Since its introduction, interest in the concept has resulted in significant research, critiques, and commentaries (Burston & Tuckett, 2012). Over the last decade there has been a surge of interest in the concept due to this growing empirical and theoretical body of knowledge on moral distress as it relates to the individual (moral agent) and large-scale system problems within organizations (structure) (Hamric, 2012; Musto, Rodney, & Vanderheide, 2014). What is known about moral distress has emerged from the profession of nursing through small descriptive studies using quantitative and qualitative methods of inquiry. Most of this research focused on the constraints experienced by front-line acute care nurses in regards to their clinical decision-making and issues between themselves and the employing organization or professional associations (Burston & Tuckett, 2012; Gaudine & Beaton, 2002; Gaudine, LeFort, Lamb, & Thorne, 2011; Gaudine & Thorne, 2000). Researchers are just beginning to explore

moral distress within other disciplines capturing previously missed experiences and perspectives (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004). As such, research on moral distress is increasingly being conducted globally resulting in the capture of cultural differences and variability due to different understandings of professional roles (Hamric, 2012).

The rationale for conducting this research is three-fold. First, the experience of moral distress among nurse leaders is virtually absent in the scholarship body (Edmonson, 2010; Mitton, Peacock, Storch, Smith, & Cornelissen, 2011) justifying the need for and significance of this original research. Like front-line nurses, nurse leaders also work in an increasingly complex work environment where they, too, are confronted with significant constraints and stress (Udon & Care, 2012). All nurses, including nurse leaders, are susceptible to ethical conflict; however, little research has been conducted on their experiences and perceptions of constraints and the enactment of moral agency. While the clinical function and role of leaders are different from front-line nurses, ethical issues and concerns are also embedded in their everyday activities. With the absence of information on moral distress and leaders, this study will further enhance the knowledge on cultural differences and variability within professional roles specifically within those who lead the health care system.

Second, historical economic/political/organizational pressures within the health care system in Canada have affected the individual employee (agent) and organization (structure) resulting in less than optimal work environments, increased stress, injury, illness, and decreased patient service delivery (Storch et al., 2009). Duncan, Rodney, and Thorne (2014) noted that one of the corollaries of these historical changes in Canadian health care has been the growing shortage of regulated nurses compounded by the profound loss of 7,000 (29%) nursing leadership positions in the 1990s, creating greater responsibility and span of control for the

remaining nurse leaders (Canadian Nurses Association, 2009; Laschinger & Wong, 2007; McCutcheon, Doran, Evans, Hall, & Pringle, 2009). The significance of these historical influences combined with evidence of the pivotal role leaders play in improving work environments (e.g., nursing satisfaction, staff retention, positive patient outcomes, and quality of service delivery) and the expectation for nursing leaders to resolve moral distress is a further reason for conducting this study (Clifford, 1998; Ganann et al., 2010; Laschinger et al., 2008; MacPhee & Bouthillette, 2008). One can assume the influence of these socio-political dynamics on individual nurse leaders is significant impacting job satisfaction and retention of nurse leaders, both of which hold organizational implications for the future. While the scholarship body has explored moral distress and its impact from the lens of front-line health providers, there is a paucity of knowledge on those who are held responsible and accountable for mitigating moral distress. The research of Storch, Makaroff, Pauly, and Newton (2013) articulated the struggles of nursing leaders and the need for guidance to help provide the necessary support for ethical nursing practice of front-line nurses. This dissertation study will explore the ethical dimensions that create moral distress for leaders, illuminate their experiences and capture their perspective and recommendations for personal and system mitigation strategies for moral distress (further enhancing job satisfaction and retention) within the highly complex work environment of health care.

Finally, one of the goals of this research is to tease out the “so what” of the findings and offer recommendations for action to mitigate the experience of moral distress for nursing leaders. While recommendations on mitigation of moral distress have been discussed in the literature, these are specific to health care leaders to utilize for their employees (Burston & Tuckett, 2012; Mitton et al., 2011; Storch et al., 2013). Very few studies have focused on recommendations for

leaders regarding how to mitigate their experiences of moral distress. Additionally, there have only been three interventional studies to date in the literature overall (Beumer, 2008; Rogers, Babgi, & Gomez, 2008; Sporrong, Arnetz, Hansson, Westerholm, & Hoglund, 2007) illustrating further study is required for intervention, specifically the needs of nursing leaders. With nurse leaders playing a pivotal role in the delivery of patient care, recommendations on mitigation strategies for moral distress will be identified that will inform real-world clinical practice, nursing leadership, organizations, and policy makers. These findings will have application for nursing leaders, employees, organizations, and patient care, further advancing the understanding of moral distress.

Guiding Research Question(s)

The intent of the following research questions was to gain a deeper understanding and clarity of the phenomenon of moral distress from a different disciplinary perspective. These questions were designed to provide considerable flexibility for the research participants to share their personal experiences, perceptions, and navigation of moral distress within their leadership role. These questions provided a vehicle for illuminating the nurse leaders' voice in the academic literature by bringing their stories and experiences of moral distress as leaders into the forefront of literature. The following research questions framed this interpretive description (ID) study:

1. How do health care nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian health care system?
2. What institutional, professional, and personal approaches and resources do nurse leaders recommend to address moral distress and how does the interpretation of those recommendations help us understand the situation of nurse leaders?

3. What are the implications for nurse leaders' real-world practices that promote the development of a positive quality of personal and professional life for leaders, and what are the policy implications for institutional healthcare environments to diminish conditions that produce moral distress?

Philosophical Foundations

In order to more fully situate this study, a brief overview of several theoretical foundations that serve as a framework for the literature review and subsequent research is shared below. Creswell and Clark's (2011) asserted a framework is required for thinking about how philosophy fits into the design of a research study. Their conceptualization was derived from Crotty's (1998) work that denoted four levels: epistemology, theoretical perspective, methodology, and methods. Figure 1.1 offers a visual representation of the four philosophical foundations that guided this study.

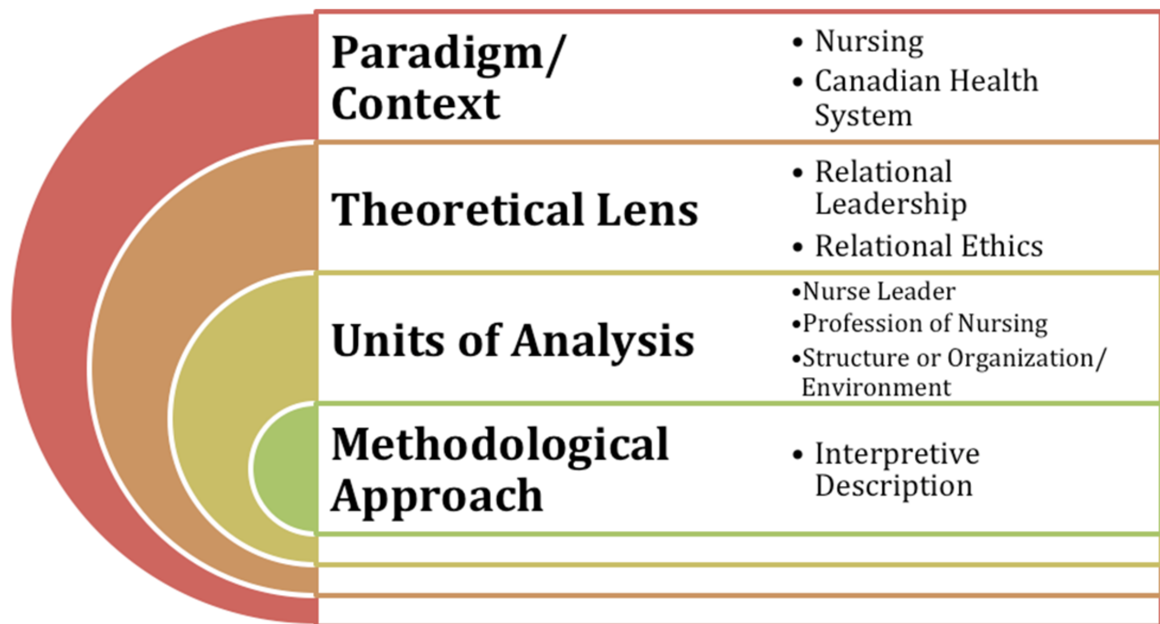

Figure 1.1. Theoretical foundations for literature review and research design from "Designing and Conducting Mixed Methods Research," by J.W. Creswell and V.L. Plano Clark, 2011, p. 39, Los Angeles, Sage.

This study is anchored within the paradigm/context of the Canadian health care system and the profession of nursing. This is important to acknowledge for two reasons. First, the level of complexity and unpredictable change faced by organizations today is unprecedented. Peter Vaill (1996) poignantly described the metaphor of *permanent whitewater* to define the difficult conditions under which individuals must exercise their will and judgment within society's organizations. He argued that everyone within a macro system experiences turbulence and instability in addition to internal, personal stresses. The health care system is one example of a macro system that is inherently complex with a unique set of challenges that can create and contribute to moral distress within health care professionals. As corporate and commercial values flood the Canadian health care system, a customer service model has been embraced by health organizations promoting extreme efficiency, predictability, and control (Austin, 2011). Leaders are "dealing with accelerating rates of change, uncertainty, and ambiguity and often work in politicized organizations where they have to deal with a wide variety of ethical issues" (Cunliffe, 2004, p. 408). Consequently, this is a challenging era for health care professionals and nursing leaders within Canada because of the complex system and political issues that have surfaced. To provide context and, more importantly, allow the reader to understand the relevance of the issue studied, a brief overview of Canadian health care policy and the challenges within contemporary Canadian and British Columbia's health care systems is discussed.

The second paradigm/context anchoring this study is the profession of nursing and the nursing framework. Thorne (2013) stated the *work* of nursing follows a logic model unique to the profession. She asserted the following:

> In a dynamic and cyclical manner, it engages, assesses, interprets, plans, acts and evaluates. It can be characterized as inherently complex and messy, dealing with an infinite range of possible variables that may enter into relevance from time to time. No matter how extensive our general knowledge of a phenomenon, we cannot enter into a

> case of it with absolute confidence in which variables are likely to come into play, and we cannot assume that, because we have seen something like it before we know what to do with it. So nursing always works with the question of generalities because we do require textbook knowledge, but with the understanding that general claims must be framed as amenable to the variance of the practice context. (p. 296)

This cyclical framework is in constant motion with nurses integrating theoretical and empirical knowledge with observation and pattern recognition. While one part of a system or concept is explored (in this case moral distress), in nursing, the system/concept is always viewed as part of a whole that can and does change due to the dynamic nature of life. Consequently, while key definitions and the conceptual development of moral distress are critically reviewed, other related concepts including individual and professional variables and the structure within which the professional is situated are also discussed. From a nursing lens or paradigm, these related concepts are assumed to be connected to the whole picture of the ethically difficult situation that creates moral distress.

The theoretical lens embraced throughout my study is one of leadership, specifically relational and ethical leadership as it applies to nursing. Simply stated, leadership is a vital component within any organization. There have been multiple examples in history, such as the Enron case, that have illustrated how leaders can injure or destroy the organization and those who work within those macro systems (Burke, 2009). Nursing leadership provides the direction and infrastructure within the health care industry to ensure nurses are empowered to practice professionally and deliver high-quality care (Laschinger et al., 2008). Leadership is required more than ever before to help guide people through difficult conditions and adaptive challenges. Unquestionably the next decade will bring with it continued change, increased challenges, and added pressure of doing more with fewer resources and tighter timelines. As such, the need for adaptive and authentic leadership, where leaders are obliged to do what is right for the follower

and critically understand their values and a deep sense of self (Northouse, 2010), will be one of the philosophical foundations explored in this study. Scholars of nursing have recognized ethics as a component of moral distress and metaphorically describe it as an overarching umbrella under which moral distress is located (Lutzen & Kvist, 2012; Varcoe et al., 2004). Subsequently, Chapter II briefly discusses relational ethics and the linkage between nursing and the concept of moral distress.

To gain a deeper understanding of the concept of moral distress, it is important to explore the units of analysis of the concept. In this study, these include the individual (nurse leader), the profession (nursing), and the structure or organization/environment. From an individual perspective, moral distress has a strong link with the profession of nursing due to the close physical proximity nurses have to their patients and the ethical and moral issues that go hand in hand with patient care (Peter & Liaschenko, 2004). It is because of this proximity that nurses are most affected by moral distress (Houghtaling, 2012). In addition, the structure or organization/environment also contributes to and is impacted by moral distress. Research linking the impact of moral distress to the structure or environment includes Wilkinson's (1987) initial study where it was found that 12% of nurses left nursing because of moral distress; a subsequent study of critical care nurses found that 13% of nurses had left nursing positions and 5% the profession because of moral distress (Corley, 1995). The significance of these nursing statistics highlight the importance of healthy work environments and the impact moral distress can have on organizations and their workforce; potentially, such a statistic as this one could extend to include nurse leaders. The concept of moral distress is currently being explored through a variety of health care disciplines indicating this phenomenon extends beyond the clinical bedside within the health system to additional levels of decision-making and roles. The intent of this

study is to further explore the relationship between the individual (nurse leader) and structure (organization) by bringing the experiences of moral distress of nurse leaders to the discourse of this phenomenon. Chapter II explores the literature around moral distress and its relationship to the nurse leader, the profession of nursing, and the organization in more detail.

The last philosophical foundation that influences this research study is related to the methodological approach selected and the associated assumptions of that method. There are several philosophical assumptions underlying ID that influence this study. The first assumption is that there are multiple constructed realities. There is no singular objective reality; instead, reality is complex, contextual, constructed, and ultimately subjective. The second assumption is that the inquirer and the inquiry interact to influence one another; the two are inseparable (Thorne, 2008). In addition, the researcher and participants create or construct their understanding of the phenomena. The participants construct the statements or claims that become data, and the researcher constructs findings on the basis of the data (Paterson, Thorne, Canam, & Jillings, 2001). As such, theory must emerge or be grounded in the data, and no a priori theory can encompass the multiple realities that are likely to appear. Good qualitative inquiry cannot be a secretive endeavor; for this reason, all of these assumptions must be acknowledged and taken into consideration for this study.

The Research Design

The methodological design used for this study is interpretive description (ID). A relatively new qualitative method, the origin of ID is derived from nursing epistemology and borrows the best techniques from traditional social science methods (grounded theory, phenomenology, and ethnography) but excludes the rigid rules embedded within each traditional method. The allure of ID is that it offers flexibility and creativity within the research design,

allowing for knowledge generation relevant to complex clinical questions within the applied health sciences (Thorne, 2008, 2016; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Historically, a quantitative positivist research paradigm has dominated and informed health care and nursing practice since the late 19th century (Polit & Beck, 2012). While quantitative research is essential in health care, other methods like qualitative research offer alternative ways to capture knowledge at junctions between practice and theory, making these methods equally important (Thorne, 2014). After reviewing the scholarship body, I observed a need for an alternative perspective to existing quantitative findings on moral distress within nursing leaders. While there is a small body of qualitative research on moral distress in leaders (Ganz, Wagner, & Toren, 2014; Gaudine & Beaton, 2002; Mitton, Peacock, Storch, Smith, & Cornelissen, 2010; Mitton et al., 2011; Pavlish, Brown-Saltzman, So, & Wong, 2016; Porter, 2010; Shirey, Ebright, & McDaniel, 2008), there remains little overall understanding of the implications of moral distress on nursing leaders. My intent is to contribute additional, more in-depth data to the overall understanding of the experiential perspectives of nurse leaders within the Canadian health care system by using a qualitative constructivist approach.

Although ID is a new methodology, it uniquely positions the researcher to partner with the participants to share the current reality of the clinical experience through the extension of participants' stories. ID minimizes the distance between the researcher and participant and allows for the participants closest to the phenomena to share their voices, experiences, and interpretations of their lived reality. The nature of this qualitative study is to advance professional knowledge by capturing the subjective and experiential elements of moral distress within nurse leaders in health care. Specifically, this study adds to the body of scholarship by

identifying potential themes and patterns, shared by the research participants, that may provide deeper meaning and links between known elements of moral distress and the larger experiential context of patient care. Data provided by the participants supplements the literature by documenting which clinical and administrative experiences create moral distress for nurse leaders as well as delineating how nursing leaders not only experience and perceive moral distress but also understand this phenomenon. It offers insight into their responses to moral distress and how these responses impact their relationships with themselves, their employees, and their organizations but, more importantly, how patient care is impacted.

Understanding the Context: The Canadian Health Care System

The Canadian health system is a dynamic, complex, and politically driven system that is constantly changing. Allen and Warner (2002) asserted, “a health care system functions within the sociopolitical system of the country in which it is situated. . . . [and is] an exemplar of the culture and philosophy of that country” (p. 96). This is particularly true of Canada where citizens embrace this public system, which is a national icon that has become embedded in the values and culture of Canadians.

Canada is the second largest country in the world with a population estimate of 35 million people (Statistics Canada, 2014a). After centuries of significant immigration, the population is culturally diverse with a system of government that embraces a publically funded paradigm for the delivery of health care. The Canadian health system offers deep, but narrow, coverage to its citizens for the costs of hospitals and physicians with varying levels of public and private coverage for pharmaceuticals, home care, and long-term care (Simpson, 2012).

Like many health care systems, the Canadian system is under pressure. “As people age, as the number of those with chronic illnesses increases, and as newer technologies become

available, the demands on health care increase, often beyond what our current system can deliver" (Storch et al., 2009, p. 1). These pressures, in turn, transfer to the clinical/organizational environment and to those who work within them.

In order to place the following theoretical discussion of moral distress within a specific Canadian health care context and appreciate the challenges nurse leaders experience within the system, it is necessary to discuss the macro-external constraints within the health care system and the internal constraints specific to nurse leaders. These include reviewing the constitutional arrangement and division of power within Canada, discussing health care expenditures, understanding the evolution of health care policy, learning about the four venues in accessing care in Canada, and reviewing demographics and ethical issues in health care (Lewis, Donaldson, Mitton, & Currie, 2001). The following analytical framework (Figure 1.2) will provide the foundation for the following discussion. This framework is reflective of the three primary underlying causes of moral distress found in the literature and my own experience working within several provincial hospital environments. I readily acknowledge that this is not an exhaustive list and is based on the literature search I conducted and my preconceptions of the Canadian health care system. The focus is on several of the key external and internal tensions present in the Canadian health care system and nursing leaders. To give context to the framework, the external constraints are represented by dark red boxes, the funnel represents the internal constraints within the nurse leader, and the shaded, light red background represents the ethical situation found in the health care organization. The following discussion will briefly discuss the external constraints within the health care system and the influence it has on creating moral distress within individuals and the health system.

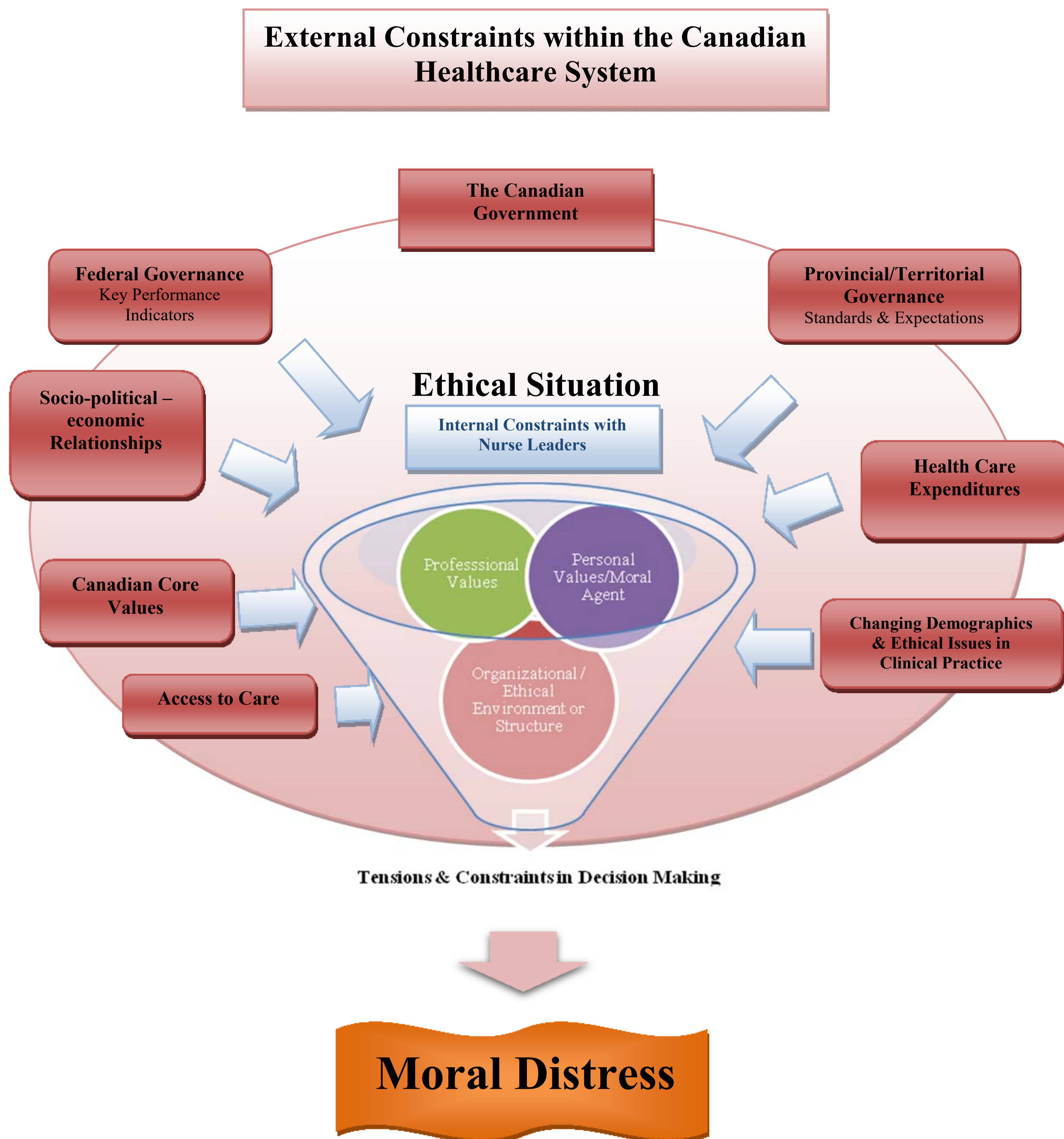

Figure 1.2. Analytical framework of external and internal factors in Canadian health care contributing to moral distress.

The Canadian government and health care. Canada is a democratic constitutional monarchy, with a sovereign as head of state and an elected prime minister as head of government. There are 10 provinces and three territories within the country (Figure 1.3). Central to the Constitution Act is the establishment of a federal system in Canada where there are two levels of government: the federal (national) government and the provincial (regional) governments. Each level of government has its own constitutional powers and jurisdictions and is charged with various responsibilities. The federal government is responsible for issues affecting the whole country, such as immigration, national defence, and trade with other countries. The provinces and territories are responsible for education, roadways, and the delivery of health care services that include the vast majority of Canadians.

Figure 1.3. Provinces and territories of Canada. Reprinted with permission from Government of Canada, 2006. Retrieved from http://www.nrcan.gc.ca/terms-conditions/10847

The health system is a publicly funded health-insurance program (called Medicare) designed to ensure every resident of Canada receives medical care and hospital treatment without financial barriers. The financial cost of care is primarily assumed by the provinces and territories and funded through general taxes or compulsory health-insurance premiums. While the provinces and territories hold the majority of legislative authority in health care and direct the delivery of services, the federal government also holds significant influence in the development and implementation of health care policy within the country. The most influential way the federal government applies its influence/power over health care is in its spending power. Every year the federal government transfers billions of dollars to the provinces to support the delivery of health services. Conditions are attached to the funding, creating stipulations for the provinces that are often not met as many of the provinces cannot afford to do otherwise. Consequently, the superior financial power and influence the federal government embodies create an external tension between federal and provincial governments that impacts health care (Romanow, 2003).

The evolution of health care policy: Canadian core values and relationships. To understand the current Canadian health care system, one must acknowledge its evolution and its connection to core values and relationships. As leadership scholar Donna Ladkin (2010) noted, the experience in the here and now is derived from the history of past events that, in turn, have shaped future events. This is particularly true of Canadian health policy where core values are tied to the very understanding of Canadian citizenship and health care policy within the country (Romanow, 2003). Over the last century, health policy has also been shaped by several significant social, political, and economic forces which will briefly be discussed here as they continue to exert tension on the health care system and likely contribute to the experience of moral distress among Canadian health care professionals and nurse leaders.

The foundation of Canadian health policy begins with its citizens and the values they embrace. In the young and developing Canadian nation predating Confederation (1867), self-reliance was an important value among Canadians. Wallace (1950) noted those who were unable to make their way and needed the support of community were viewed as lazy or weak. With social problems reserved for family, friends, or religious organizations, self-reliance fueled the belief of "limited government involvement in social security other than a modicum of services for the sick, the mentally ill, and delinquents" (Storch & Meilicke, 1994, p. 22). Ultimately the subject of health care was largely neglected by the government with authorities only engaging with major health issues when epidemics threatened the populace (Heagerty, 1934; Storch, 1985).

Historically, such values have played a significant role in the creation of health policy but so, too, have politics. The limited evolution of mid-nineteenth century medicine and the laissez-faire ideas about individual initiative and social provision affected the constitutional arrangements within the Constitution Act of 1867 (Baumgart, 1992). While the Constitution outlined an organizational structure for the new nation dividing powers between the provincial and the federal governments, it did not anticipate the societal changes that would dramatically alter the health and welfare of the nation. All matters of national concern thought to be costly (e.g., railways, canals, quarantine, marine hospital, armed forces, and First Nations people) were delegated to the federal government which had the broadest tax base (Deber & Vayda, 1992). The provinces were given the responsibilities of the "establishment, maintenance, and management of hospitals, asylums, charities, and . . . institutions in and for the province, other than marine hospitals" (Deber & Vayda, 1992, p. 3). Wallace asserted the authors of Confederation believed they were allocating provinces the inconsequential and inexpensive

functions of government as the cost of public charities, social welfare, and education amounted to 9% of total government expenditures at that time. In contrast, by 2000, provincial and territorial health care financing was estimated to command as high as 85% of all public sector expenditures, with the federal share being less than 15% (Provincial and Territorial Ministers of Health, 2000). Historically, the provinces have always had insufficient tax bases to support extensive services to meet the needs of the Canadian public. The impact of this allocation has created an imbalance between fiscal resources and constitutional responsibilities, making federal-provincial relationships contentious and the primary concern of Canadian politics and health care.

The period between Confederation (1867) and World War II witnessed several events (economic, social, and political) that underscored an awareness within the government of a growing need to deal with the social security needs of the public within an increasingly urbanized and industrialized nation (Storch, 1985). Canada experienced several economic depressions, resulting in widespread unemployment where the ideals of self-reliance were substituted by the realities of the peoples' growing interdependencies (Baumgart, 1992; Wallace, 1980). Contributing to the economic hardships were rising rates of disease (tuberculosis, typhus, and typhoid), malnutrition, and the general poor health of Canadians (evidenced by the high rate of rejection of recruits for World War I) which triggered a growing public demand for social services and a new need for federal assistance and programs (Splane, 1965; Storch, 1985; Wallace, 1950). Canadians, who were directly responsible for payment of health services, began to default on payments of medical and hospital bills or simply stopped using health services (Baumgart, 1992; Health Canada, 2011). This created an additional economic impact as physicians' incomes declined, hospital deficits grew, and local authorities (unable to cope with

the increasing numbers of unemployed) turned to the provincial and federal governments for assistance.

The federal government finally took steps to develop a plan for Canadian health and welfare services during the Second World War. Following the lead of Franklin D. Roosevelt and Winston Churchill, the Canadian government signed the Atlantic Charter in 1942 which called for the development of a better society post-war: one liberated from hunger, disease, unemployment, and war (Canadian Museum of History, 2010). This charter generated the creation of an advisory committee on health and also commissioned two significant reports, the Marsh Report of 1943 (see Marsh, 1975) and the Heagerty Report (1943). These reports paved the way for universal health care coverage in Canada.

In 1947, the Premier of Saskatchewan, Tommy Douglass (the father of Medicare) introduced the Saskatchewan Hospital Services Plan, which became the very first universal hospital care plan (Simpson, 2012; Storch & Meilicke, 1994). Once again, Canadian values influenced health policy as this plan was founded on Douglas's passionate belief that every Canadian deserved the right to have quality health care, regardless of their economic or social situation (Government of Canada, 2015). This was the first compulsory and comprehensive hospital insurance plan in North America (Simpson, 2012). Under this plan, the provincial government assumed hospital related costs for its residents and financed the program through a combination of annual health premiums charged to residents and general provincial revenues (Makarenko, 2008). Other provinces quickly followed Saskatchewan's lead, and in 1957 the passage of the *Hospital Insurance and Diagnostic Services Act* was adopted, becoming the cornerstone of Canada's current health insurance system (Iglehart, 2007). This federal legislation was significant in that it committed the Government of Canada to finance 50% of the

cost for specified hospital and diagnostic services, based on a cost-sharing formula (Iglehart, 2007; M. Taylor, 1973). Agreements were in place with all provinces by 1961, providing hospital coverage across Canada (Makarenko, 2008; Storch & Meilicke, 1994).

Political and social tensions escalated again in Saskatchewan in 1962 when Douglas's government introduced a Medical Insurance Plan. Strong opposition and resistance occurred from the medical profession resulting in a 23-day physician strike. The root of the conflict was physicians' opposition to a compulsory, government-run plan (Simpson, 2012). Public opinion moved against the striking physicians, and this policy prevailed where physicians billed the government directly for services they provided to the patients (Storch & Meilicke, 1994). To appease the physicians, amendments were introduced allowing physicians to opt-out of Medicare, raising fee payments under the plan, and creating a practice called extra billing where physicians could charge higher fees than those reimbursed by the government. To this day an undulating tension remains between the governments and physicians regarding fee payments and services which influence the rest of the health care system through a fiscal allocation of health care expenditures.

In 1968 the federal *Medical Care Act* was introduced. Under this legislation, the federal government committed to reimbursing or cost sharing one-half of the provinces and territorial costs for medical services provided by a physician outside of hospitals (Health Canada, 2011; Iglehart, 2000). In addition to this, to qualify for federal-provincial cost-sharing, the provincial programs had to meet requirements that created a new tension within the system. These stipulations included (a) universal access to care on uniform terms and conditions, (b) portability of benefits from province to province, (c) coverage of all medically necessary acute care services and (d) public administration on a non-profit basis (Deber & Vayda1992; Iglehart, 2000).

Moreover, the Act limited the provinces' discretion in charging health care premiums or in allowing user fees and extra-billing by hospitals and physicians (Makarenko, 2008). Reluctance was demonstrated by some provinces to adopt public medical insurance, but Deber and Vayda (1992) noted that "it was politically difficult for a province to justify having its citizens' federal tax dollars going to support programs in other provinces" (p. 5). By 1972 each province adopted universal medical care insurance although there were significant differences from one province to another and how each paid for its system. The federal government was now an important financial partner in public health care and was able to influence provincial policy indirectly in this area through the conditions it attached to federal health funding under the Medical Care Act (Makarenko, 2008).

In 1984, the federal government introduced the *Canada Health Act* replacing the hospital and medical insurance acts and establishing criteria for portability, accessibility, universality, comprehensiveness, and public administration (Health Canada, 2011). The legislation also included provisions that prohibited extra billing and user fees for insured services. This again ignited tension and created bitter opposition to the act by the provinces and organized medicine as resented intrusion into what was considered "their constitutional domain" (Storch & Meilicke, 1994). The federal government also expressed concern over the rapidly escalating costs of social services and in its ability to continue paying for 50% of what provinces spent (Makarenko, 2008). What began in the 1960s with a 50-50 division of cost sharing in health care had by 1995, through a series of sometimes negotiated and sometimes unilateral changes, morphed into a national government share of funding as low as 16% (according to the provinces) and no higher than 32% (according to the national government) (Lewis et al., 2001).

As a result of this fiscal tension, multiple government inquires were carried out to examine ways in which health care could be delivered in a more cost-effective manner, primarily focusing on health promotion and primary care (Storch & Meilicke, 1994). The financial cuts from the federal government led to real constraints on health care spending in the late 1990s. Massive structural reforms occurred including (a) mergers and regionalisation that resulted in a smaller number of hospital beds (i.e., in 1991 there were 1,128 hospitals versus 877 hospitals in 1999) (Iglehart, 2000; Lewis et al., 2001); (b) an emphasis on technology to improve hospital systems and the creation of intra-institutional responsibility to improved appropriate patient placement and care alternatives (Storch & Meilicke, 1994); (c) reduction in the number of medical and nursing school seats (Iglehart, 2000); (d) a focus on community-based services and health promotion (Storch & Meilicke, 1994); and (e) a reduction in full-time employment of nurses and nurse leaders (Iglehart, 2000; Laschinger, Almost, Purdy, & Kim, 2004). The economic constraints imposed by the federal government created these health reforms, which clearly impacted the ways in which the provincial governments managed the delivery of service and the delivery of care.

The new millennium ushered in yet another key development in the story of health care policy within Canada the *Romanow Commission on Health Care (2003)*. Central to this federal report was the firm recommendation that Canada should continue to embrace a public health care system where the cost of medical services was covered by governments. The commission suggested a collaborative relationship among the levels of government wherein each level was an equal partner in public health care policy (Makarenko, 2008). It also recommended the federal government increase its share of federal funding for health care to a minimum of 25% of provincial/territorial costs (Romanow, 2003). This represented an increase over existing federal

funding levels at the time but was still lower than the 50% promised by the federal government when Medicare was first introduced. While there is criticism of Romanow's report (e.g., Simpson, 2012; Vertesi, 2003), what his report clearly outlined were how core values like equity, fairness, and solidarity have continued to play a role in our health care system. This was an essential document connecting Canadian values to health care delivery with Romano (2003) stating the following:

> Canadians' attachment to medicare is based on their understanding of it as a right of citizenship. They connect with the values that define medicare, not the particular features of the system in place in their province or territory. Canadians expect the system to guarantee them relatively similar access to a common basket of medicare services of equal quality, regardless of where they live. They expect governments, providers, and caregivers to work collaboratively to maintain a system with these attributes. (p. xviii)

Finally, the *First Ministers' Accord on Health Care Renewal* (Health Canada, 2003) and the subsequent *10-Year Plan to Strengthen Healthcare* (Health Canada, 2004) were initiated with a collaborative goal shared by the federal, provincial, and territorial governments to a 10-year plan to sustain the public health care system. Under the agreement, the federal government committed to provide an additional $18 billion to the provinces and territories for health care and a 6% annual increase in federal health transfers until 2015. This, according to the federal government, amounted to $41 billion in new funding over 10 years. This new money was in addition to the $36 billion agreed to in the 2003 accord. In return, the provinces and territories agreed to a number of federal demands in the area of waiting times and home care services. This included setting common benchmarks for measuring waiting times across the country, achieving agreed upon reductions in waiting times for medical treatment in five key areas (coronary care, cancer treatment, diagnostic imaging, joint replacement, and sight restoration). In a recent progress report, the Health Council of Canada (2013) commented on the state of the Canadian health care system's commitment to these two initiatives; the report concluded that regardless of

the objectives set forth in these initiatives, Canada's overall performance was falling behind many other high-income countries. It has also created increased pressure within the health care system for those leading the system (nurse leaders) to meet the KPIs created by wait times mandated by the federal government resulting in the potential for moral distress.

The evolution of Canada's health care policy is really a story about values, leadership, relationships, and the division of money. This discussion has illustrated how core social values like self-reliance and caring for one's family/neighbor have transferred into national core health care values like universal care, accessibility, and portability. As health policy evolved, social values, politics, and economic events have shaped the policy, influenced relationships (e.g., between governments and physicians and within governments), and created tension within the health care system: tension that is felt by those who work within the system.

Health care expenditures: socialized vs. neo-liberal funding. This external tension among federal, provincial, and health care authorities becomes evident when reviewing health care expenditures. Prada, Grimes, and Sklokin (2014) noted escalating health care costs are viewed as a grave threat to financial sustainability of health care services, especially since the growth in total health expenditures has occurred at a faster rate than the growth rate of the Canadian economy. Significant concern has been voiced concerning the cost of care and sustainability of the health care system in Canada, given the effect of an aging population on the economic growth and demand for health services (Prada et al., 2014; Simpson, 2012).

In 2012 the total health expenditures in Canada were estimated to be $207.4 billion with two-thirds of the funding (69.7%) coming from public sector sources (Government of Canada, 2013). Figure 1.4 illustrates the expenditures for health care where the provincial governments supplied the majority of funds (65.1%) with the federal government (2.9 %) contributing

significantly less. Health care costs are expected to continue to outpace the growth of the economy which has triggered ethical discussions on health care reform within government. In particular, such discussion focuses on the breadth of population coverage, the scope of benefits provided, and depth of services publicly financed to sustain the performance of the health care system (Prada et al., 2014). The sustainability of the health care system is a concern for Canadians and governments alike as evidenced by the continued and persistent demands within these populations such as:

- increased acuity and co-morbidity of illness,
- gaps in the mental health services for children/youth/adults with moderate to severe mental illness and/or addictions,
- the requirements of an aging frail elderly population needing quick response for hospitalization or residential services,
- emergency department overcrowding and congestion due to the care of admitted inpatients
- long wait times for specialists, diagnostic imaging, and elective surgeries, and
- access to inpatient beds due to bed blockages from lack of acute and residential capacity in the health care system (British Columbia Ministry of Health, 2013).

Among the Organisation for Economic Co-operation and Development (OECD) countries, Canada ranks among the highest in per capita spending on health where total spending is approximately 11% of the gross domestic product and almost half of provincial budgets (Prada et al., 2014). Cost containment/sustainability, the division of funding responsibility, and government expectations are some of the biggest tensions within the health system. This contributes to multiple challenges and stressors for nurse leaders who must manage these system

pressures that include issues of capacity, congestion, and financial targets. Balancing the population health care needs/demands with quality nursing care while navigating the economic and political constraints imposed by governments to control and sustain health care costs can contribute to moral distress.

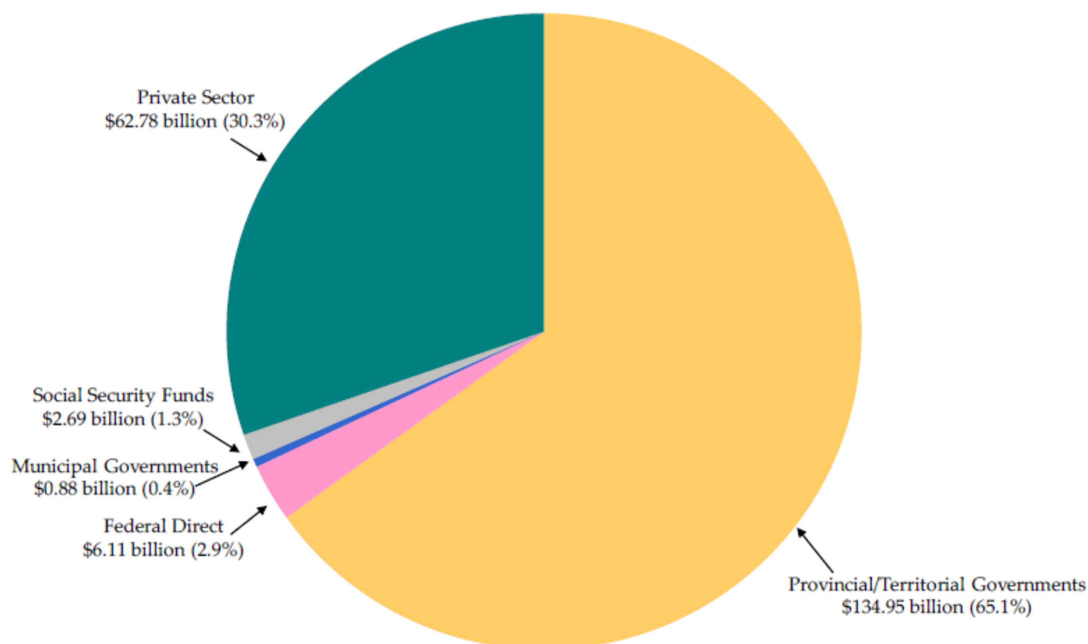

Figure 1.4. Total forecasted health expenditures in Canada by funding source. Retrieved from "Healthy Canadians—A Federal Report on Comparable Health Indicators 2012" by Health Canada, 2013, p. 6. Copyright 2013 by Her Majesty the Queen in Right of Canada, represented by the Minister of Health. Reprinted with permission.

There remains a strong belief held by Canadians that the public health care system should deliver more without requiring them to pay more for it (British Columbia Ministry of Health, 2013; Health Council of Canada, 2013). As such both provincial and federal governments are challenged by having to meet the increasing costs of health care without raising taxes. Health policy reforms have been implemented over the years by governments to address the fiscal tensions created in the delivery of public health care. Several reforms have been driven by a neo-liberal ideology that has been present since the 1970s. Neoliberalism is derived from two notions—'neo' meaning new and 'liberal' inferring free from government intervention

(McGregor, 2001). McDaniel and Chappell (1999) noted the neoliberal agenda of health care reform includes cost cutting for efficiency, decentralization to the local or regional levels rather than the national level, and the set up of health care as a private good for sale rather than a public good paid for with tax dollars. The discourse on opportunities in leveraging private sector resources and partnerships to optimize population health outcomes has been a contentious issue within governments and the public sector (British Columbia Ministry of Health, 2013; Romanow, 2003; Simpson, 2012; Whiteside, 2009). Whiteside argued that opening up the delivery of health care infrastructure and support services to private for-profit companies, undermines the safe delivery of health care that Canadians and health care professionals expect. Within nursing, discourse has also occurred regarding the impact of dominant political, ideological, and social values on organizations and professions. In a classic paper by Annette Brown (2001), locating nursing in the dominant political ideology of liberalism (Neoliberalism), she argues that the central tenants of this ideology (individualism, egalitarianism, freedom, tolerance, neutrality, and a free-market economy) have shaped the views of individuals and society, the focus of knowledge development in nursing, and the vision of the social good. These influences create tensions from recognizing political ideological values that fall outside the realm of nursing such as policies on privatization impacting the delivery of patient care, decreased government intervention, cutbacks in social programs, and an increasing emphasis on individual responsibility and self-reliance.

Access to care: four categories of care. As a publicly funded or socialized system of health care, Canadians have access to four categories of health care. Primary care is the dominate category of care accessed by Canadians. It is the first point of consultation and treatment for patients in the health system and one that guides the patient through the system ensuring

continuity of care when more specialized services are required. Primary care usually involves general practitioners, family physicians, nurse practitioners, nurses, physiotherapists, and social workers (Canadian Institute for Health Information, 2013***).*** The typical forms of care include routine care for minor illness, healthy child development, basic emergency services, primary maternity care, rehabilitation services, health promotion, and disease prevention.

Secondary care involves the provision of a specialized consultation or medical service by a hospital or physician specialist (e.g., cardiologist, urologist, psychiatrist, plastic surgeon, etc.) created by a referral from a primary physician. This category of care is delivered in a variety of settings such as acute community-based hospitals, emergency departments, long-term care facilities, and hospice where treatment for a short period of time is required for serious illness or injury (Health Canada, 2011). Primary or secondary health care professionals refer inpatients to tertiary care when patients require advanced medical investigation and treatment. Tertiary care is specialized consultative care which has historically been associated with academic or teaching hospitals. Examples of tertiary care include neurosurgery, burns, trauma, neonatology, and other complex medical and surgical interventions.

Home and community care, the final category of care available in Canada, has been supported by provincial and federal governments in the last few decades. Unlike services currently defined as medically necessary, home care is not an insured service under the *Canada Health Act*; it is an extended service where there is no obligation on the part of the government to provide a minimum service (Health Canada, 2011). The philosophy is that home, with appropriate supports, is the best place to recover from illness and injury, manage chronic conditions, and live out the final days of one’s life. Home care clients obtain such care for three reasons: acute care substitution, long-term care substitution, and prevention and maintenance

(Canadian Health Care Association, 2009). Those patients who access this category of care are those living with mental health conditions, one or more chronic conditions, and the frail elderly. A strong expectation of family cooperation is required and necessary to assist in this level of care. While the current economic climate has created health care reforms that have enhanced resources to home and community care, this will not reduce the pressure and stress within the health care system to focus on acute care services and infrastructure to support the public demand; people still become acutely ill and require hospitalization.

On a daily basis British Columbians have experienced thousands of successful interactions when accessing care in the Canadian health system. It is equally important to recognize that despite successful efforts where quality of care was delivered, there continue to be persistent challenges and issues in the delivery of care and across service areas such as:

- proactive and quick responses to changing complex needs of the frail elderly living in the community to reducing the need for hospitalization;
- gaps in the continuum of mental health and substance use services for adults and children;
- long wait times for specialists;
- access to inpatient beds in hospitals;
- human resource challenges;
- requirement for coordinated system-wide discharge planning; and
- extreme congestion in ED as populations grow (British Columbia Ministry of Health, 2014).

These are large scale system challenges occurring in organizational settings. The literature has emphasized the distress experienced by direct care professionals within these settings (Austin,

Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Mitton et al., 2011; Wlody, 2007). Nursing leaders are finding themselves challenged by increasingly complex ethical issues created by accelerating rates of change, uncertainty, fiscal restraints, and ambiguity within the politicized organizations where they practice. They observe how these factors impact patients' access to health care and in the delivery of health care services. These are known tensions leading to stress and value conflicts that create moral distress that extends beyond the clinical bedside and affects health care professionals at all levels of the organization, including nurse leaders, further justifying the need for this study.

Demographics and ethical issues: The health care system in British Columbia. The majority of this dissertation research will be conducted within the province of British Columbia. The provincial government's Ministry of Health has overall responsibility for ensuring that quality, cost effective, and timely health services are available to all British Columbians (British Columbia Ministry of Health, 2013). The Ministry sets province-wide goals, standards, and expectations for health service delivery by health authorities. This is accomplished through the development of social policy, legislation, and professional regulation, through funding decisions, negotiations and bargaining, and an accountability framework for health authorities (British Columbia Ministry of Health, 2013).

Canadians are living "long and healthy lives, reflecting the nation's affluence, enviable living conditions and health and social-service systems" (Canadian Nurses Association, 2012, p. 8). While the health needs of many are being met, the health care system continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, a rising burden of illness from chronic diseases, mental illness and cancer, and advances in technology and pharmaceuticals driving new costly procedures and

treatments (Canadian Health Services Research Foundation, 2011). While Canadians are living longer, an aging population brings new challenges in the delivery of health care as patterns of illness change, which is particularly true of the province of British Columbia. Seniors comprise 16% of the current total population with this number expected to double within the next 25 years (British Columbia Ministry of Health, 2013). With this shift in age and care needs, more health services like sufficient nurses and physicians, prescription, home health and residential care services will be required. In addition, there will be increasing need to consider the impact of frailty, dementia, and other health issues on seniors and their families and focus on providing appropriate care, enhancing quality of life, and supporting healthy aging in the community. Chronic diseases such as diabetes, depression, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis, asthma, and some cancers are also increasing in prevalence. People with chronic conditions represent approximately 38% of the British Columbia population and consume approximately 80% of the combined physician payment, pharmaceutical and hospital care budgets (British Columbia Ministry of Health, 2013). British Columbia also faces a challenge to ensure that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal people has improved over the past few decades, this population in British Columbia continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other residents of British Columbia (British Columbia Ministry of Health, 2013).

The dominant tension within British Columbia and across Canada is rooted in the impact of funding to the provinces and the cost of care. In British Columbia, the Ministry of Health reported health spending was growing faster than the economy with a steady increase from $9.2 billion in 2001 to over $16 billion in 2012 (British Columbia Ministry of Health, 2013). As a

consequence, there is tremendous focus and pressure to control fiscal resources and meet budget allocations within health care. This tension trickles down to the front lines of care where leaders are confronted with how to provide safe and ethical care for their patients with limited resources. Additionally, funding reductions have resulted in restructuring in health care organizations over the past two and a half decades. This focus on efficiency and restructuring of resources has resulted in efficiency-driven patient care, casualization of nursing positions, reductions in clinical nursing leadership, and the subordination of patient care goals to institutional goals (Austin, 2011; Rodney, Buckley, Street, Serrano, & Martin 2013; Rodney, Doane, Storch, & Varcoe, 2006). Thus, patients, families, and communities are experiencing increasing difficulty accessing safe, effective, and ethical health care, and the impact on health care providers—especially nurses—has been serious (Rodney, Buckley, et al., 2013, p. 160). There is constant pressure on those leading health care (nurse leaders) to meet the quality and safety metrics set by provinces as related to the timing of scheduled surgery, wait times for diagnostic tests, improved patient flow, and length of stay or patient discharge criteria. The constraints within the system and its (in)capacity to meet them potentiates the occurrence of moral distress.

The following discussion has specifically examined macro-external constraints present within the current Canadian health care system that is thought to contribute to moral distress. In Canada, health care policy has been shaped by several significant social, political, and economic forces that have generated tension within the system and consequently for those who work within the system. While the literature has examined the critical impact of the organizational setting on distress experienced by those directly working with the patient (Austin et al., 2005; Wlody, 2007), limited attention has been given to nursing leaders and their direct experience with moral distress triggered by external constraints within the health care system. Moral distress

significantly impacts the organizational environment operationally and financially through job satisfaction (Corley, Elswick, Gorman, & Clor, 2001), staff morale (Gaudine & Beaton, 2002; Rodney & Starzomski, 1993), and absenteeism (Gaudine & Thorne, 2000). This occupational form of stress is known to cause adverse effects both personally and organizationally; therefore, gaining a deeper understanding of nursing leaders direct experiences and perceptions of moral distress is relevant.

Providing this overview of the evolution of Canada's health care system and policy was essential as it provides historical context and exposes undercurrents that can create moral distress within health care professionals and leaders. Canada's health system is in a constant state of flux, rapidly changing yet firmly based on Canadian values that have played a significant role in the creation and legislation of health care policy. It is a universal system funded through federal tax revenue allocated to the provinces, which has created tension between the governments and health authorities. Provinces must comply with tenets of federal health legislation articulated in the Canada Health Act; otherwise, funding will be lost. As such, key performance indicators (KPIs) to account for funding are mandated by the federal government, and in turn, the provinces set expectations and standards for health authorities to ensure that KPIs are met and funding is secured. It falls on hospital leaders and nurse managers to implement these mandates as well as predict how government regulations and planning could potentially circumscribe management's ability to develop and implement a coherent strategic plan to meet standards of practice and the safe delivery of quality care (A. D. Brown, Aikman, & Sandoval, 2005).

Multiple scholars have researched the impact of fiscal restraint and stress on patient care delivery and among the health care professionals (Baumann et al., 2001; Duncan et al., 2014; Laschinger, Sabiston, Finegan, & Shamian, 2001; Laschinger et al., 2008; Lynam et al., 2003).

Continued rising costs and differences of opinion between governments on issues such as the *Canadian Health Act*, waiting times, home care, physician fee structure, and pharmaceutical coverage, all continue to be sources of animosity between governments, and, consequently, those who lead within the health care system and organization. That these constraints continue to intensify and remain prevalent further situates the relevance of this research study that examines the experiences of moral distress from a leadership context.

Positionality of the Researcher

My interest in the phenomena of moral distress and leadership originates from my background as a registered nurse and Canadian nurse leader. The profession of nursing is unique in that it allows one to walk beside individuals as they journey and transition through different stages of life—from birth to death. My scope of practice as a nurse has evolved over the last 20 years, through specialization in the area of emergency nursing and advancement of practice from the clinical bedside to a formal leadership role as an operational director of multiple programs including emergency, critical care, and medicine. My passion and interest in nursing is based on a fascination of the pathophysiology of the human body, the variety of clinical presentations, and accompanying adrenaline rush of never knowing what will roll through the ED doors, as well as my mother who not only instilled a set of core values of helping others, but also acted as a role model and mentor as a registered nurse who specialized in emergency and residential care for over 40 years. As a teenager, I recall my mother sharing her experiences in providing nursing care to patients and in her role as a nursing leader (circa 1960–2000s). Her stories were captivating, from the joy of delivering a new baby and the tragedy of a drunk driver who killed a family in a car accident to the frustrations of working short-staffed, implementing new health policy impacting patient care, or firing an employee due to workplace theft and substance use.

After I entered the profession of nursing, I, too, soon had my own experiences and began to understand the exquisite and privileged role of being a registered nurse. When I assumed a leadership role, I also gained a new appreciation and understanding for the responsibilities leaders carry and the ethical challenges they encounter within their day-to-day work.

My curiosity in moral distress among nursing leaders has emerged from several poignant events in my nursing career. My initial intrigue came to light through my doctoral journey. Over the last five years, my studies have focused on a variety of topics relevant to my clinical practice including nursing leadership in health care, overcrowding in the ED, and patient satisfaction. My curiosity regarding moral distress appeared after an interview for a case study I conducted with an executive nurse leader. This leader shared her experience of a government mandated directive she had to implement that would impact the delivery of patient care. She shared the constraints she felt as she navigated this difficult ethical initiative and openly discussed the moral distress she experienced personally and professionally. This was a poignant experience for me as a nursing leader and as an emergent scholar. As a middle manager at the time of the interview, I naively assumed the intensity of moral distress at senior executive levels of leadership were minor due to the distance from the patient. As a scholar, I was left with the question of how constraints within an organization impact the work and lives of all nursing leaders.

As I progressed through my doctoral studies, moral distress became an unconscious underlying theme in many of my assignments. I began to observe and critically reflect on ethical challenges and the resulting distress that occurred within the leadership role. Within the work environment, I began to critically observe, listen, and reflect on how I, and fellow leadership colleagues, discussed and responded to ethically challenging situations. During one memorable

business meeting in the fall of 2013, I once again observed how constraints within an organization impacted the work of leaders and the impact it might have professionally and personally. The purpose of the meeting was to discuss new fiscal restraints affecting patient care delivery, wage freezes, and the increased workload of leadership. The tension within the meeting was palpable as many leaders spoke of the constraints and moral conflicts within the leader role and their personal lives.

The academic literature (Edmonson, 2010; Mitton et al., 2011; Rodney et al., 2013) is robust with moving descriptions of moral distress experienced by front-line nurses. As an emergency and critical care nursing leader for over a decade, I have not only witnessed moral distress within nurses, but also within myself and other leaders. Health care leaders often find themselves faced with dual loyalties in conflicting situations due to tensions between organizational responsibilities and professional nursing values (Toren & Wagner, 2010). What is surprising is the limited research on how leaders experience moral distress in the work environment, which suggests an assumption that displaying negative emotions is discouraged and considered unprofessional, especially within a leadership role (Kramer & Hess, 2002). Capturing the voices of the nurse leaders and gleaning their understanding and perceptions of moral distress in their day-to-day work is important as this can also lead to exposing coping strategies leaders currently use to mitigate moral distress for their employees, themselves, and the overall organization. This study addresses the experiences of nurse leaders in acute care hospital settings as moral distress appears to be a prevalent and hidden undercurrent within the whitewater of Canadian health care.

Overview of Dissertation Chapters

Chapter II offers a comprehensive discussion of the concept of moral distress within health care, specifically nursing. The underlying purpose of this dissertation is to better understand how moral distress impacts nurse leaders and the health care system so the first section of Chapter II contextualizes the nurse as leader, exploring variables that contribute to moral distress. A brief overview of the concept, its evolution and key related concepts from an individual and organizational lens, are then explored to provide a deeper understanding of the foundational research of this phenomenon. This chapter also provides a review of moral distress in other industry sectors, identifying similarities and learnings that can be referenced by nurse leaders in the mitigation of moral distress.

As a nurse, I want to investigate a phenomenon that intrigues me, but, more importantly, I want the freedom to utilize a research approach that most closely reflects the practice knowledge needed in the clinical environment to impact positive change. Chapter III presents a relatively new qualitative framework that has become popular within the nursing profession, interpretive description. An introduction to the method is provided to assist readers who are unfamiliar with the methodology, and it details the procedures used to conduct the study and analyze the data. This study is conducted in the context of a particular sector of health care (acute care) and in a particular country (Canada) within a group of research participants deemed experts by the researcher and their position within the health care system.

In Chapter IV, the qualitative results of the research interviews are presented. In this chapter, the data gathered during data collection was immense, offering a further depth of learning and contribution to the scholarship of moral distress and within health care leadership practice. The patterns of themes and metaphor generated from my research are discussed in

detail. These findings lend further insight into the complexities of moral distress within nursing leaders and its link to clinical practice and the delivery of patient care.

Chapter V provides a discussion of the interpretations of the findings and links these back to the relevant literature and theory on moral distress and leadership. Delimitations and limitations of the study will be outlined. As a practitioner-focused dissertation with applied research, this chapter includes implications on or recommendations for nursing and administrative leadership practice, real-world practices, policy implications for institutional health care environments, and future research on leadership and the mitigation of moral distress. As a reflective practitioner and scholar, the concluding section outlines my positionality and my reflections of my experience studying this phenomenon.

Chapter Summary

In this chapter, I have asserted that there is a significant gap in the current body of scholarship regarding the experiences and perceptions of moral distress within health care leaders. The inspiration for this research is grounded in my own past experiential experience and my current academic intrigue with the concept. Through a brief synopsis of the constitutional arrangement and history of health care policy, I established that the foundation of Canadian health policy originated with its citizens and the values they embraced. Over the last century, health policy has been shaped by several significant social, political, and economic forces that have exerted tension on the health care system. By understanding the historical and socio-political factors influencing health care, one gains a better understanding of the tension and moral distress it is creating for health care providers at all levels within the organization, including nurse leaders. Moral distress is a pervasive problem for all health care providers, and

by using an ID methodology this study will add new knowledge to the discourse on the concept from a nursing leadership lens.

Chapter II: Literature Review

The importance of moral distress for nursing practice has been widely acknowledged and discussed in the academic literature and professional regulating bodies for decades (American Association of Critical-Care Nurses [AACN], 2006; Canadian Nurses Association [CNA], 2008; Kopala & Burkhart, 2005; NANDA International, 2003). Specifically, research has focused on how moral distress relates to the direct care health professionals (primarily nurses), the patient, and the organization. Although these areas are well explored, a critical review of the literature revealed a paucity of research on the experience, perceptions, and navigation of moral distress on those leading contemporary health care systems. The significance of this observation is paramount and is supported by several researchers who have poignantly acknowledged how clinical situations and stories haunting front-line health care professionals are the same ones haunting nurse leaders (Edmonson,2010; Rashotte, 2004). This provocative and powerful assertion communicates the potential anguish and torment created by ethically challenging situations and the far-reaching impact from the clinical bedside to the top tiers of the organization. The voices of nurse leaders and their stories and experiences of moral distress are visibly absent from the literature, revealing a missing depth of understanding about the phenomenon.

The purpose of this chapter is four-fold:

1. to contextualize the nurse as leader,
2. to explore the scholarship on moral distress within the health care industry,
3. to look at the relationship between the structure or organizational/ethical climate and the moral agent, and

4. to examine leaders' experiences in navigating ethically troubling situations in other industry sectors for relevant learning to help inform how nurse leaders navigate moral distress.

The first section contextualizes the nurse as leader. Nursing leaders, across the spectrum of health care, are faced with complex situations that require instantaneous problem-solving, decision-making, actions, and results. Often some of these ethical situations are new and unique to organizations or even health care itself. One such example in Canada is new legislative policy (Bill C-14, 2016) amending the criminal code to allow medical assistance in dying. Bill C-14 (2016) "creates exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying" (p. 1 Summary). With the passing of this new legislation, physicians, nurses, and nursing leaders are grappling with organizational policy and guidelines on how to enact this legislation. In situations like this policymakers, organizations, and nurse leaders must make informed, quick, and unified decisions that impact not only the patient, but also the family, employees, and local/ global community. In making such decisions, "individual managers who feel compromised by organizational decisions may face extreme adversity and distress" (Mitton et al., 2011, p. 108). The moral and ethical challenges associated with unique situations such as Bill C-14 in hospital settings as well as other more common daily issues like shortages of resources fall on those leaders closest to patient care—the nurse leader. To understand how and why moral distress affects nurse leaders, their roles, responsibilities, and expectations from an ethical context are explored.

Second, an overview is provided of the evolution of the concept and characteristics of moral distress. This section focuses on providing a conceptual understanding of the phenomenon

and its primary characteristics. The discussion benefits from a further brief overview of seminal research specific to moral distress and the leadership role that offers an important foundation for this study.

A third section explores the relationship between the structure or organizational/ethical climate and the nursing leader. The work climate construct has been an important unit of discourse for scholars in understanding organizations and organizational behavior. A brief discussion on current research in this area as well as an overview of universal tensions present within hospital organizations is discussed.

The chapter's final section shares research on how leaders across industries other than health care perceive, experience, and navigate moral dilemmas and ethical stress. This analysis provides an opportunity to explore how these leaders experience and manage ethically troubling situations and if any key learnings can be applied to health care as it relates to moral distress. The section concludes by pointing to significant gaps in this literature and subsequently positioning this dissertation study.

The Nurse as Leader

Within the on-going discussions about health care in Canada, one of the topics receiving significant attention from scholars, practitioners, and policymakers is nursing leadership. Nursing leadership "plays a pivotal role in the immediate lives of nurses, and it has an impact on the entire health system and the Canadians it serves" (Canadian Nurses Association, 2008, p.1). More specifically, nursing leadership provides the direction and infrastructure within the health care industry to ensure nurses are empowered to practice professionally and deliver high-quality care (Laschinger et al., 2008).

In the late 1980s and 1990s, governments across Canada took profound steps to control their health spending. The result was dramatic restructuring characterized by cutbacks in health spending, closure of hospitals and beds, layoff of nurses, and a reduction of approximately 7000 clinical leadership positions (Austin, 2012; Canadian Nurses Association, 2009; Scott-Findlay, Estabrooks, Cohn, & Pollock., 2002;Varcoe & Rodney, 2009). It was shortly after these changes that articles within the nursing literature began to appear about moral distress (Fenton, 1988; Fowler, 1989; Storch et al., 2013; Wilkinson, 1987). The issues identified in these articles not only highlighted the importance of the supportive role required by nursing leaders in health care, but also assigned responsibility to these nurse leaders to address moral distress in the working environment (Bell & Breslin, 2008; Canadian Nurses Association, 1985; Storch, Rodney, Pauly, Brown, & Starzomski, 2002;Wilkinson, 1987).

Nurse leaders are different from other health care leaders in that they shift between the clinical and organizational/administrative domains in health care settings and help shape the nursing profession to be responsive to the ever-changing health care system. These leaders are responsible for understanding the context of patient care and the values espoused by the profession, and leading their teams with clinical judgment, wisdom, and knowledge through ethical challenges within the system. While the expectation is to uphold these responsibilities, there have been instances where nursing leaders have been perceived to have fallen short in their responsibilities or turned a blind eye to a problematic situation (Gaudine et al., 2011). A few scholars have acknowledged that nurse leaders experience ethical problems in their work: the most common related to the allocation of resources and quality of care (Aitamaa, Leino-Kilpi, Puukka, & Suhonen, 2010; Borawski, 1995; Mitton et al., 2010, 2011). In a cursory review of the literature, Storch et al. (2013) noted research on this topic of ethics and nurse leadership is

limited, with only a handful of articles published since 1996. The authors noted the struggles of formal nurse leaders regarding ethical situations and responsibilities within the role, advocating for attention and support for nursing leaders to help navigate the ethical responsibilities of the leadership role (Storch et al., 2013; Varcoe et al., 2004). Given the increasingly complex nature of the socio-political climate and disciplinary, interdisciplinary, and professional issues in nursing and health care, a more in-depth understanding of ethical situations creating moral distress for nursing leaders is required to further support front-line nurses and providers. The following section contextualizes the nurse as leader by discussing the roles and responsibilities, explores character traits and moral experience, examines the expectation of being a moral agent, discusses professional values, and offers a theoretical perspective upon which this study is grounded.

Roles and responsibilities. In Canada, nurse leaders include front-line, middle, and senior managers; directors, executives, or administrators; professional practice leaders; researchers; and policymakers (Laschinger et al., 2008). Examples of nurse leaders as defined for this study are clinical program managers of acute care programs (e.g., emergency departments, intensive care units, medical/surgical units and mental health units), directors, and executive directors of specific programs, and nursing leaders in senior corporate roles such as a vice president of a health authority.

Nurse leadership responsibilities include those functions that focus on relationships in the organization that fosters an environment that enacts organizational priorities (Shirey & Fisher, 2008). The complexity of the role demands strong interpersonal and communication skills, adaptability, responsibility, accountability, political astuteness, vision, and the ability to think and act outside of boundaries while avoiding professional derailment. Responsibilities of nurse

leaders are diverse and vary in complexity for each level of leadership. There has been a significant amount of research on the role and performance expectations of the nurse manager (Hall & Donner, 1997; Laschinger, Purdy, Cho, & Almost, 2006; Redman & Fry, 2003; Shirey, 2005, 2006; Shirey & Diahwe, 2008). This role varies regarding organizational context, focus, and location (Briggs, Smyth, & Anderson, 2012). Clinical nurse managers are responsible for the daily operational management of hospital units and for actively engaging with front-line health care professionals and patients. The role commands competence in multiple areas including human resource management, finance and budget management/allocation, conflict resolution, job satisfaction/retention, legal risk management, information technology, and patient care issues (Hall & Donner, 1997; Huber, 2000; Laschinger et al., 2006; Redman & Fry, 2003; Shirey, 2005, 2006; Shirey & Diahwe, 2008; Tomey, 2009a, 2009b; Yoder-Wise, 2007). Ultimately, managers are responsible for creating a work environment that prioritizes patient safety while meeting financial targets set by the organization and provincial government (Page, 2004). Nurse managers must also address the needs of multiple stakeholders (patients, staff, physicians, senior leaders, and community) while balancing these elements and managing the ethical challenges present when caring for humans in a complex system like health care. Managers hold 24-hour responsibility for their specific acute/critical care area (Anthony et al., 2005: Mathena, 2002) and provide a link between the clinical bedside and senior nurse leadership.

As leadership roles advance, this connection with the manager and the clinical bedside remains important. Senior nurse leaders, like program directors, executive directors, and vice presidents/CEOs, must maintain a strong link with the daily operational issues of the organization as well as engage in strategic planning for the organization. This planning involves

creating and maintaining a comprehensive continuum of services and emerging health care needs of the organization and population as a whole as directed by provincial and federal mandates. These leaders must navigate the multiple political influences within and surrounding the organization and understand the impact of all decisions on the organization (McCue, 2011). Furthermore, like nurse managers, they serve as a role model for ethical conduct and must embody a strong commitment to personal moral integrity when organizational factors and goals are in direct opposition to their moral values (Curtin, 2007; McCue, 2011).

Nurse leaders at every level play a crucial role in translating the organization's mission, vision, and values, as well as new health initiatives mandated provincially/federally, into caring work environments and a lived reality (Shirey, 2005). Toren and Wagner (2010) argued that the nurse leader role inherently encounters conflict due to the dissonance between management values and professional nursing values. The challenge becomes one of how to navigate between the delivery of care controlled by economic targets when they clash with the moral implications and actual outcomes for the parties involved (e.g., patients, nurses, organization, community, and profession) (Jormsri, 2004). The essence of nursing management includes relationships among organizational stakeholders who bring different interests and pressures. Hence, leaders must provide answers and make decisions that may result in a contradiction of the expectations of employees with those of the organization, the employees with those of the patients, or employees with those of the profession, creating stress for leaders (Toren & Wagner, 2010).

While each leadership role experiences political and ethical conflict differently due to role complexity, nurse leaders who are actively engaged with the bedside nurse are more inclined to experience moral distress as it pertains to the patient and the close proximity of care. There is a dearth of literature to support this although one qualitative study of mid and senior-level

managers in two British Columbia authorities refutes this assumption, noting moral distress is experienced by mid-level and senior managers (Mitton et al., 2011). In this study, senior leaders indicated they did not lack understanding or empathy for the patients' personal consequences. Mitton et al. asserted that moral distress is experienced at all levels of leadership with subtleties inferred within the hierarchy of leadership, indicating the need for additional investigation. This dissertation study sought to determine whether differences in moral distress existed among leadership roles and, if it did, to identify the perceived differences within the leadership echelons.

The individual as a nurse leader. "Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?" (Nightingale, 1861). As I reflect on this statement, articulated over a century ago, I am humbled by Nightingale's poignant acknowledgment of the moral tension/distress health care providers and leaders continue to grapple with regarding patient care. The central tenet of this quote illustrates the ever-present tension and struggle between the individual and the environment as it pertains to ethical care in health care delivery. Nightingale's words imply the importance of personal values, one of the foundational underpinnings of moral distress. Personal values or beliefs make up an integral part of one's self-concept and are passionately held (Gaudine & Beaton, 2002; Rokeach, 1973; Uustal, 1978). Every individual develops a set of core values and beliefs that evolve from formal learning and role modeling within social circles including family, teachers, ministers, and peers (Beauchamp & Childress, 2001). These provide "the framework for one's view of the world and one's place in it, and for distinguishing right from wrong" (Gaudine & Beaton, 2002, p. 17). An interesting theme within the literature illustrates how personal values are linked to other value systems

associated with nursing: professional values and organizational values which can create moral distress (Gaudine & Beaton, 2002; Musto et al., 2014; Nathaniel, 2006). As such, health care providers are not solely self-interested but are relationally embedded in a socio-political world that shapes the available course of actions and involves meaningful relationships where the interests of others matter (Carnevale, 2013). This is particularly true of nurse leaders where they have multiple loyalties when faced with ethical situations where personal, professional, and organizational values conflict. Nurse leaders have an obligation to protect patients, families, and staff pertaining to a concern for their health and quality of care, while complying with the organization's needs for cost-effectiveness and efficiency (Toren & Wagner, 2010). The complexity of the current health care environment translates into a variety of ethical questions and decisions about patient care where tensions occur among multiple value systems (Musto et al., 2014). The following discussion explores the nurse leader first as an individual through character traits and moral experience and then as a moral agent and how these two points of view can contribute to moral distress. This section also outlines the theoretical perspective I bring to this dissertation study, which is important when conducting an interpretive descriptive (ID) study.

Character traits and moral experience. Character traits and moral experience are other significant themes acknowledged in the moral distress literature. Several researchers have explored the phenomenon at the micro-level of analysis, focusing on the relationship between character traits and personal qualities (Hanna, 2004; Tiedje, 2000; Wilkinson, 1989). Burston and Tuckett (2012) argued that moral distress is linked to how nurses perceive their role and concluded that in whatever role the nurse embodied, knowledge, perceived skill level, and confidence all compounded the moral distress experience (Laabs, 2005; Pauly et al., 2009; Rice,

Rady, Hamrick, Verheijde, & Pendergast, 2008). Ohnishi, Ohgushi, and Nakano (2010) also underscored how increased levels of moral distress are correlated to an increase in the degree of authority a nurse possessed. Perceptions of moral distress were also believed to be developed from cumulative life experiences and prior experiences in similar or identical situations (Burston & Tuckett, 2010). These findings all speak to the need for additional research into the experiences of leaders and their moral distress, especially because nursing leaders have remained voiceless, having been identified in the literature as the canary in the mineshaft (Austin, 2012).

Hunt and Carnevale (2011) proposed a theoretical framework to assist in understanding how individuals live out the moral dimensions of their lives. They assert the moral experience is a hermeneutic and subjective experience in which a person senses or perceives values he/she considers important as either realized or thwarted in everyday life. This creates a person's interpretation of a lived encounter or a set of lived encounters that fall on a continuum of right-wrong, good-bad, or just-unjust (Hunt & Carnevale, 2011). This theoretical framework of moral experience evolved from the work of previous scholars including Taylor (1991), Heidegger (1962), and Gadamer (1960). These researchers asserted moral matters were grounded in a person's moral ontology or the unspoken beliefs held by a person or a group of individuals. "In this way the person as a moral agent stands against a background or *horizon of significance* constituted by the context that the agent resides within and the socio-historically based moral order within which meaning is rooted for her or him" (Hunt & Carnevale, 2011, p. 659). Consequently, subjective experiences are based on how things matter to an individual and how the individual experience is enacted within a particular context of meaning. The moral experience involves a sense of how things matter in relation to a person's value system. This framework strives to understand the perspectives of individual experiences. As clinical

environments continue to increase in complexity and as organizational constraints and pressures build, nurses and nurse leaders will continue to experience moral distress. As these health professionals advocate for patient's rights, they will act as moral agents based on their education and socialization. While the moral experience is subjective, the reality is that the foundation is deeply anchored in personal and professional values.

The moral agent. The expectation of individuals who enter the profession of nursing is that they adhere to the ideals and moral norms of the profession and embrace these norms and ideals as part of who they are as individuals (American Nurses Association, 2016). The Canadian Nurses' Association's (2008) Code of Ethics echoes this expectation through its articulation of the need for nurses to acknowledge and recognize that they are moral agents in providing patient care. This is further reflected in the Canadian Nurses' Association's (2008) definition of a moral agent/agency as "the capacity or power of a nurse to direct his/her motives and actions to some ethical end, essentially doing what is good or right" (p. 26).

Being a moral agent bears a significant responsibility for conducting oneself ethically in what one does and in how one interacts with individuals who are under the nurse's care (Canadian Nurses' Association, 2008). Peter and Liaschenko (2004) defined moral agency as "the capacity to recognize, deliberate/reflect on, and act on moral responsibilities" (p. 221). To experience moral distress, these researchers assert an agent must have some degree of autonomy in recognizing and reflecting on moral concerns yet be constrained in acting on the moral responsibility he/she understands him/herself to have. Thus, Peter and Liaschenko contend that "moral distress presumes a situated agency, an agency that is not entirely free, nor entirely encumbered" (p. 221).

Rodney and colleagues (Rodney et al., 2002; Rodney et al., 2013) offered a different and unique perspective on moral agency. They utilized a nautical metaphor to describe the nature of the nurse's experiences with ethical decision-making and their role as moral agents. This metaphor describes "the processual and contingent nature of nurses' experience [with] the notion of a moral horizon reflect[ing] 'the good' towards which the nurses were navigating" (Rodney et al., 2002, p. 89). They suggested that currents are present in the moral climate of nurses' work which influences the individual nurse's progress. In addition, Rodney et al. (2002) asserted nurses, including nurse leaders, are navigating against strong currents specially created by biomedicine and a corporate ethos that impede enactment of the nurse's moral agency. This has created increasing moral angst in the nursing profession (Rodney, Kadyschuk, et al., 2013) as the difficulty encountered while navigating and enacting moral agency leads to the internalization of the constraints and potential moral distress. While these scholars focused on the experience of acute clinical nurses, one can surmise that nurse leaders, who straddle the clinical and administrative domain, also experience the same angst and consequences of moral distress. The overarching irony is the internalization of these constraints or pressures impact the well-being of not only patients, but also care providers and leaders, which, in itself, is an ethical issue (Hamric, 2002; Storch et al., 2009b; Varcoe & Rodney, 2009).

Over the last two decades the socio-political climate under which nurses and nurse leaders enact their moral agency has been impacted due to changes in the moral climate and systems within the Canadian health care system. These fundamental changes include new care delivery models, nurses' capacity to work to full potential, quality of nurses' work lives, demographic shifts in society and nursing, and the power of the profession to influence systems (Duncan et al., 2014; National Expert Commission, 2012; Nelson et al., 2014). Canadian nursing

has experienced a prolonged period of difficult and new challenges where systems designed to assist with complex ethical situations (e.g., ethics review boards, emergency operation centers, critical incident stress debriefing, etc.) are often unavailable or equipped to respond in a timely manner to keep up with front-line health care delivery needs and decisions. Scholarship on theory and practice in health care has predominantly discussed ethical problems as dichotomous (yes/no) issues about what moral agents should do in critical or ethical situations (Rodney et al., 2013; Rodney et al., 2002). The reality of the current health care environment is that a dichotomous answer is not always appropriate even if foundational ethical principles—autonomy, beneficence, non-maleficence, and justice—are applied (Beauchamp & Childress, 2001; Rodney et al., 2002). Rodney et al. (2002) argued that it was assumed that "objective, rational, analytic process will furnish a concrete and correct answer, outside the familial, social, cultural, and political context of the problem" (p. 92). While it is logical to conclude that answers can easily be found using these foundational ethical principles, the infinite number of ethical challenges and constraints within the organizational environment is not always conducive to concrete, correct, and timely answers, especially when the variables of the ethical issue are constantly changing or complex.

The complexities of these ethical challenges have implications for nursing leaders specific to their relationships with others in the organization. One of the disheartening discussions captured by several researchers is a belief held by nurses that their leaders are reluctant to raise ethical concerns or advocate for clients or staff. Gutierrez (2005) originally noted a fissure or tension among leadership, staff, and organization regarding the management of moral distress. Gutierrez found nursing management was not cited by any of the nurses as a support for moral action. Several nurses felt the nurse manager was unaware of the moral

conflicts or the nurse's experience with moral distress. One nurse stated, "I certainly don't think nursing matters. I think our administration's actions speak very clearly in that they regard nursing as a liability. . . . We're a liability to be paid out" (Gutierrez, 2005, p. 237).

The chasm and tension between nurses and leadership regarding moral distress were also articulated in another study conducted by Storch et al. (2002). In this study nurses expressed concerns about nurse leaders' actions or inactions. Some nurses remarked leaders were as powerless as staff nurses in being voiceless and unable to effect improved practice environments while others expressed frustration that leaders were unwilling to take the power that was perceived to be theirs. There was some empathy shown for nurse leaders who were considered to be held captive by unreasonable managerial responsibilities. Only in occasional instances were nurse leaders' actions described as helpful or supportive in the nurses' ability to be moral agents and to engage in safe, competent, and ethical care. The leaders in this study spoke of having their hands tied and were sensitive to their potential to be too assertive out of fear that they may be marginalized by the other administrators. The disconnect between the constraints experienced by the managers and the lack of support felt by nurses remains the current reality of today's health environment and further supports the need for additional research.

Scholars have argued that "power inequities in contemporary health care policy processes have interfered with nurses' abilities to provide good quality patient/family/community care" (Rodney et al., 2013, p. 204). From an organizational perspective, one factor contributing to this observation is the ethical conflict between the leadership/administrative role and the leader's professional role. Each role holds specific values and goals with the nursing profession's focus on providing high-quality care for all patients and the organizational role advocating fiscal restraint and efficiency (Aitamaa et al., 2010; Borawski, 1995). Nurse leaders are socialized as

nurses but speak on behalf of their organizations, highlighting the conflict and fine line leaders navigate between the clinical and organizational domains. Gaudine and Beaton's (2002) study on the ethical conflict between nurse leaders and organizations described the nurse manager's ethical conflicts and value differences with their employing organizations. They found four themes of ethical conflict:

1. voicelessness;
2. financial constraints related to distress due to unmet patient or staff needs;
3. the rights of the individual versus the needs of the organization; and
4. unjust practices of senior administration and /or the organization.

Several participants in this study shared feelings of isolation because their attempts to influence decision-making were not accepted. Unaware of the extent of the barriers facing managers, the nurses often harshly judged managers for failing to fix the issues. These researchers were the first to advocate for support for managers in their quest to provide a nursing voice at senior organizational levels.

Duncan et al. (2014) also commented on how nursing is lagging in its power in political process capacity. Reflecting on health economist Stephen Lewis's (2010) characterization of nursing as having "so many voices, so little voice" (p. 40) versus medicine's lower numbers and greater political strength, Duncan and colleagues (2014) attribute this to the loss of nursing leadership positions at senior decision management tables. "The presence of nursing within national and provincial governments has been eroded in many jurisdictions, and there has been serious disruption in the scope and mandate of the various bodies within organized nursing" (p. 625). This can generate significant moral distress for nurses in leadership roles, which is

further supported by other scholars (Gaudine & Beaton, 2002; Mitton et al., 2011; Musto et al., 2014).

Gaudine and Beaton (2002) were also the first to question if nurses are truly aware of the extent of nurse managers' feelings of distress and powerlessness or their need for the support of the staff. They suggested managers often feel alone and overburdened in their search for solutions. These researchers suggest the need to shift the responsibility to a shared collective and recommend further education on ethical issues and for managers to "learn how to share their burden and their role as a nurse leader's voice within the hospital" (p. 31). Little subsequent research on this issue has occurred since 2002, which supports the need for this current dissertation study. The importance of added research is echoed in Rodney, Buckley, et al.'s (2013) assertion that nurses' voices are not being heard in part due to the powerlessness experienced by nurse leaders in corporate health care. Rodney, Buckley, et al. (2013) recommended several things to assist in navigating towards a moral horizon including enhancing the quality of relationships between colleagues, using the language of ethics in a way that supports nursing practice, and improving the moral foundations of health policy. This accentuates the importance and influence of the relationship between the agent and the structure within the health care system.

One final essential element about moral agency is its relational element. Peter (2011) argued that moral agency is more than a characteristic possessed by one individual, but, rather, it was a "relational or socially connected characteristic of individuals in such a way that we can, at least to some extent, recognize, reflect on and act on moral responsibilities as a collective (p. 12). What is important to note is that nurses as moral agents act within a relational socio-political context (Carnevale, 2013; Rodney, Buckley, et al., 2013). Rodney, Buckley, et al. (2013) credit

Mackenzie and Stoljar (2000) with the poignant assertion that agents are relational "because their identities or self-conceptions are constituted by elements of the social context in which they are embedded" and "because their natures are produced by certain historical and social conditions" (p. 22). This, they argued, supports an interrelationship between structure and agency, where structures are "mutually sustaining cultural schemas and sets of resources that empower and constrain social action" (Rodney, Buckley, et al., 2013, p. 162). Furthermore, presence is also important. Rodney, Buckley, et al. (2013) elaborated that individuals must be present to be effective moral agents. Being present involved being "in the here-and-now of the actual patient care situation" and "trying to understand what their colleagues and /or patients and family members are experiencing" (p. 179). With nurse leaders straddling the clinical, professional, and organizational domains of health care they must translate the work or essence of nursing to the ethical situation and advocate on many levels (professional, patient, and organizational) for the delivery of safe patient and staff care. It is when values and commitments cannot be enacted that nurses' identity and integrity as moral agents are affected and moral distress occurs (Canadian Nurses Association, 2008).

Professional values. Health care providers are educated and socialized to their professional values and ethics during their academic preparation and ongoing professional development (Gaudine et al., 2011). What is essential to understand about nursing is that fundamental values like caring and compassion fuel the profession. Most individuals who chose this profession do so because these core values intimately resonate with long-standing personal values that are based on historical, cultural, and social processes experienced by the individual (Faith, 2013; Hunt, 2011b). The challenge faced by nurses and nurse leaders has been to maintain these fundamental values within health care in an ever-changing global society.

Political, economic, and technological forces are constantly influencing and reshaping the landscape of health care in Canada, causing a cultural shift in the moral foundation of the nursing profession and challenging providers upholding their core professional values. This can (and does) create ethical or moral distress for all who work in the health industry, including leaders. The following section briefly discusses the relevance of the professional code of ethics for nurses and provides a poignant example of the failure of leadership in a health care system where professional values in the delivery of care were compromised.

Code of ethics relevance to leadership and its evolution. Many countries have codes of ethics that guide health care professionals (Aitamaa et al., 2010). These codes outline foundational values of the profession and inform professionals on how they should act based on these values. Over the last 30 years, the Canadian Nurses' Association has maintained a code of ethics that serves as a foundation for ethical practice (Canadian Nurses Association, 2008). The code states the ethical values of nurses and outlines their commitment to individuals with health care needs and to those receiving care. Periodically, revisions are made to reflect the changing values, experienced and created by society that will impact the delivery of care.

In light of the increasing complexity of the health care environment and influences shifting the culture of care (e.g., performance expectations, technological advancements, finite resources, and competitive globalization of health care) disagreement on what is morally right occurs in patient care (Edmonson, 2010; Nathaniel, 2006). The code of ethics provides an ethical basis from which nurses can advocate and support the delivery of safe, compassionate, and competent care. The code articulates that nurses are responsible for the ethics of their practice and delegates health care leaders as stewards of care charged with preserving and promoting what is intrinsically valuable about the nurse-patient relationship—care. The code

cannot guaranty ethical practice; however, elements are also outlined for nurses to uphold including “a commitment to do good; sensitivity and receptiveness to ethical matters; and a willingness to enter into relationships with persons receiving care and with groups, populations and communities that have health-care needs and problems” (Canadian Nurses Association, 2008, p. 4).

While the current Canadian code clearly articulates that the ethics of nursing practice is a responsibility shared among nurses, this has not always been the case. Professional associations (American Association of Critical Care Nurses, 2005; Canadian Nurses Association, 2008) and researchers (Bell & Breslin, 2008; Corley & Raines, 1993; McAndrew, Leske, & Garcia., 2011; Shirey et al., 2008; Storch et al., 2013) have consistently assigned responsibility to health care leaders for resolving moral distress in the environment and creating and maintaining cultures that support nurses. Storch et al. (2013) underscored how the evolution of the code of ethics in Canada was very clear in its directive, expectation, and individual responsibility of nurse leaders pertaining to preserving and maintaining healthy work environments. The original Code of Ethics of 1985 included a specific ethical standard directed to nurse leaders:

> Administrators bear special responsibilities that flow from a concern for the present and future clients. The nurse administrator seeks to ensure that the competencies of personnel are used efficiently. Working within available resources, the administrator seeks to ensure the welfare of clients. When competent care is threatened due to inadequate resources or for some other reason, the administrator acts to minimize the present danger and to prevent future harm. (Canadian Nurses Association, 1985, p. 10)

The directive to nurse leaders is clear as is how to minimize the danger and harm when there are no resources. The other more subtle undercurrent within this statement is the resulting potential moral distress created when leaders cannot minimize danger or harm, which impacts those working in the health care environment and the very leaders themselves.

Over the years, the code of ethics has also evolved in its recommendations for responding to ethically distressing situations. The 2002 Code encouraged nurses to recognize and name the ethical distress for greater awareness and to increase the odds for resolution. It suggested nurses would be less likely to use negative coping strategies like distancing and avoidance by doing this action. Nurses were also encouraged to speak with trusted colleagues outside of the situation who could preserve confidentiality and help affirm conclusions drawn. This version of the code also encouraged nurses to seek information from relevant authorities on expected roles and responsibilities and to consult with those who could resolve the issue. This recommendation for resolution of moral distress continued to highlight the overarching responsibility of leaders to resolve moral distress within their environment. The inclusion of an explicit directive to steward healthy work climates remained in subsequent codes (Canadian Nurses Association 1991, 1997, 2002) until 2008. This revision of the code was rewritten to reflect a shared responsibility amongst nurses that illustrates the progressive evolution and nature of the profession. Moral distress was also formally recognized and defined in 2008, and nurses were encouraged to engage in ethical reflection and discussion. Multiple models and frameworks for targeted issues were also recommended as tools to guide nurses in their thinking about ethical issues or problems.

The 2008 Code of Ethics acknowledges the increased complexity of the health care system and the increased ethical situations nurses and nursing leaders experience. There was criticism within the literature of this change in responsibility for nurse leaders; however, acknowledgement and recognition was also articulated regarding the unfair expectation of imposing a greater ethical responsibility on one individual or particular group of people (e.g., leaders) considering the difficulty and complexity in the current health care climate (Storch et al.,

2013). Storch et al. (2013) argue that like front-line nurses who need their leader's support during ethical situations, so, too, do formal nurse leaders who are charged with carrying out their ethical responsibilities to their staff. While several countries have formulated ethical principles and standards for management personnel (American College of Healthcare Executives, 2011; Canadian College of Health Leaders, 2013; National Health Service, 2002), several scholars suggest revisiting these ethical standards or codes of ethics for executives and managers, further questioning the usefulness of these codes in decision-making related to the changed context of nursing, dominance of fiscal restraint, intensified legal parameters, and presence of obstructive and systemic authority-gradients (Aitamma et al., 2010; Edgar, 2004; Meulenbergs, Verpeet, Schotsmans, & Gastmans, 2004; Pattison, 2001; Storch et al., 2013). In making decisions about ethical problems, scholars have noted leaders use a variety of resources such as personal values, peers, acts on patients' rights with professional codes of ethics being the least referenced (Aitamaa et al., 2010; Borawski, 1994; Cooper, Frank, Gouty, & Hansen, 2003).

In the ever-increasing complexity of patient care, co-morbidities of patient presentations, and health care systems, it is impossible for any one person to control the processes and outcomes of care (Dickens, 2012). As leaders and scholars, we have to be wary of efforts to simplify problems so that they appear solvable (Heifetz, 1994). The simplistic solution of delegating sole responsibility to leaders for healthy work environments is no longer feasible as the health system has increased in complexity, and shared collective responsibility is required.

When professional values are compromised: an English lesson. Although the Romanow Commission (2003) and subsequent health accords (The First Ministers' Accord on Health Care Renewal and the 10-Year Plan to Strengthen Health Care) outlined progressive and equitable reform measures that would enhance the Canadian system's quality and sustainability, the

Canadian government has failed to follow through with these recommendations for health care. Over the last three decades, health care restructuring in Canada has focused on efficiency versus quality of care where patient care goals are subordinate to institutional goals (Rodney, Buckley, et al., 2013). In an analysis of how political influences have shaped nursing practice and leadership in Canada, Duncan and colleagues (2014) reflected on the retrospective and prospective situation in Canadian nursing and health care delivery to garner insights from the past to gain future strategic direction for the nursing professions mandate. There are several poignant reflections in this analysis that are important to the discourse of moral distress, especially as it applies to nurse leaders and, thus, germane to this dissertation study. First, the authors comment on the impact and link of the political ideology of neoliberalism (a policy model that transfers control of economic factors to the private sector from the public sector) embraced by western political systems and the "resultant erosions in the resources for health and health care" (Duncan et al., 2014, p. 623). Second, they noted the impact of a concurrent ideology of managerialism that blossomed in the late 1980s and 1990s where the loss of clinical leadership "undermined and replaced by corporate and executive models" (p. 626) devoid of disciplinary affiliation, remains present. Coupled with the losses of nurses at senior executive policy discussions, this has resulted in a "diminished advocacy for resources and awareness of issues surrounding nursing practice and what nurses need to practice in the interests of patient and health" (p. 626) and exclusion of nursing knowledge and expertise within health policy. A third reflection voiced by the authors was the significant influence that economic turmoil and security concerns can have on national policy platforms and health care. Regardless of commitment of governments at all levels, pressing issues and concerns can lose government focus and momentum. The final reflection commented on the role overload experienced by

nurses in leadership positions and how they require clinical and education supports to cope with an increasing span of control and responsibility in their work (Duncan et al., 2014). It is clear how history and knowledge of socio-political issues provide context for understanding contemporary issues within health care and moral distress (Duncan et al., 2014).

While I have argued for the shift from sole leader to a shared nursing responsibility in the previous section, I must also acknowledge my concomitant support of the obligation leaders have to assist in creating and advocating for healthy work climates for professionals and patients. Effective leadership in clinical settings is linked to improved quality and safety (Francis, 2013; McKee, Charles, Dixon-Woods, Willars, & Martin, 2013). Leaders cannot be seen to cut corners, turn a blind eye, or ignore poor practice as this sets the pattern of behaviour for a whole team and culture (Francis, 2013; Kaufman & McCaughan, 2013; White, 2012). Having professional values and a code of ethics as nurse leaders is important as it serves as a standard of conduct that should govern individual behaviour. However, a code of ethics cannot guaranty ethical practice.

In 2013 a public inquiry was conducted into the catastrophic failings in the quality and safety of patient care at The Mid Staffordshire NHS Foundation Trust in the United Kingdom. Conducted by Sir Robert Francis, the inquiry revealed a serious breach of ethical duty. The inquiry was initiated when hospital standardized mortality ratios revealed that between 400 and 1,200 more patients than expected had died over a two-year period. Numerous patient accounts were heard by the inquiry, including negative experiences of fundamental aspects of nursing care including communication, maintenance of dignity, discharge planning, and safety (Ball, Murrells, Rafferty, Morrow, & Griffiths, 2013; Francis, 2013). Additionally, “an oppressive atmosphere in which intimidation and bullying were rife prevented staff from raising concerns,

and, when they did, swept them under the carpet" (Ball et al., 2013, p. 522). The inquiry disclosed the serious failure on the part of the trust board

> to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care. (Francis, 2013, p. 3)

The inquiry identified multiple failures including:

- a culture focused on doing the system's business—not that of the patients;
- an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- standards and methods of measuring compliance that did not focus on the effect of a service on patients;
- too great a degree of tolerance of poor standards and of risk to patients;
- a failure of communications and monitoring between the many agencies to share their knowledge of concerns;
- a failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession; and
- a failure to appreciate, until recently, the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganization. (Francis, 2013, p. 4)

What is evident from this review is the breach of ethical obligation/duty of many, a focus on business versus quality and care, and the resulting overall deterioration in nursing staff and standards of care. Francis (2013) identified the causes of organizational degradation at Mid Staffordshire as systemic, seeing the faults as institutional and cultural in character. The inquiry referenced how external constraints such as demands for financial control, corporate governance,

and regulatory systems influence the system, highlighting that it is not the system that will ensure the patient is put first: it is the people working in the system charged with developing and enacting health care and policy.

The systemic failures identified in the Francis Inquiry are not unique to England with other international health care systems and communities also experiencing significant quality and safety issues involving

- poor management systems,
- failure to respond to patient concerns,
- cultures of secrecy and protectionism,
- fragmentation of knowledge about problems and responsibility for addressing them,
- cultures of denial and uncomfortable information. (Walshe & Shortell, 2004)

Francis outlined 290 recommendations for change that, as several scholars have noted, "amounts to nothing short of a cultural revolution" (Ball et al., 2013). Ultimately, Francis (2013) called for focusing on "what is truly important," which included a strong commitment to common values throughout the British system, zero tolerance of noncompliance with fundamental standards of care, transparency and candour in all system's business, strong leadership in nursing and other professional values, and more support and training for those in leadership roles. Given the lessons learned from the Francis Inquiry, the importance of leadership, system constraints, and barriers in enacting professional moral agency only highlights the importance of further understanding moral distress among nursing leaders. Breeching professional values and sweeping issues in health care under the proverbial carpet due to system constraints clearly compromises quality and safety of patient care delivery as evidenced by the Mid Staffordshire example. Musto et al. (2014) poignantly summarized the relevance of this inquiry stating that it

> serves a powerful example of how structures and agents can influence each other in a negative way. . . . [and] serves as a warning to nurses and other healthcare providers around the globe that they may seriously fail in the fulfillment of their moral obligations if they are overly constrained by socio-political healthcare contexts driven by fiscal and other non-health-related values. (p. 93)

A theoretical perspective. The scaffold design of this current dissertation includes a theoretical forestructure of relational ethics and leadership that is relevant to this proposed research. Relational ethics is a relatively new conceptual approach informed by several theoretical lenses such as culture, ethics, feminism, phenomenology, pragmatism, and radical hermeneutics (Rodney, Burgess, Pauly, & Phillips, 2013). While influenced by a variety of theoretical perspectives, relational ethics is dynamic. A relational ethic is, as Peacock (1999) suggested, “an evolving thing, expanding in scope and effectiveness as our collectively shared experience grows—and always a bit tentative, even when it must guide us in life-and-death situations” (p. 703). Relational ethics requests one to consider context at every level—from the individual to the larger society while constructively addressing power inequities at every level (Austin, Bergum, & Dossetor, 2003; Baylis, Kenny, & Sherwin, 2008; Hartrick Doane & Varcoe, 2005; Rodney, Burgess, et al., 2013). Several scholars noted that relational ethics also encourages one to be reflective about personal positionality and embrace complexity and diversity on moving toward a moral horizon (Rodney, Burgess, et al., 2013; Sherwin, 1998).

Relational ethics places an emphasis on the community of relationships and interactions that influence the particular situation. Bergum (2004) stated that when ethical action is viewed from the perspective of a relationship rather than from theory/principles (epistemology), virtues, or problems, a moral space is created by one’s relation to oneself and others. Relational space, as a moral space, is where one is responsible for oneself and the other. Such space also becomes a space of being for and with both oneself and the other (Jopling, 2000). Another essential

element is the assumption that the other person in a relationship is like oneself. Consequently, Bergum (2004) asserted the importance of dialogue where one listens and attends to another human being, arguing "that the other may not just have a right but may actually be right, may understand something better than we do" (p. 486). The practice of relational ethics affects all levels of health care and, with relational space as the location of enacting morality, it is important to attend to the quality of relationships in all practice, whether with patients, their families, other health care professionals, or administrators and politicians (Bergum, 2013). Attention to relationships does not take away from the need to distinguish between different ethical foci or levels within the health system. "The moral community includes each of us as responsible for our actions in relation to the people we care for, educate, supervise, or work with in partnership" (Bergum, 2013, p. 129).

Bergum (2004) identified four themes to give language to a relational ethic: environment, embodiment, mutual respect, and engagement. Within the relational approach, the environment is not an object that can be manipulated and managed. Bergum (2004) argued the health care system is something more than an individual or collective body. Instead, the environment is in each individual and is a living system that changes through daily action. Embodiment "calls for healing the split between mind and body so that scientific knowledge and human compassion are given equal weight: emotion and feeling are understood to be as important to human life as physical signs and symptoms (Bergum, 2013, p. 132). Mutual respect, a central theme of relational ethics, derives from the belief that people are fundamentally connected to one another. Bergum noted that respect for differences does not come easily, and professionals grounded in their own perspective find it hard to realize that others also have a valuable perspective and may, in fact, be right. Teamwork is suggested to be a prime opportunity for relational action, with the

patient and family taking on important roles. The last theme is engagement, a shared moment between people. It is an ethical action that begins with a genuine understanding of the other's situation, perspective, and vulnerability (Bergum, 2013). This type of engagement allows nurses to develop a holistic and meaningful understanding of the patient's experience.

According to Bergum (2004), the foundation of relational ethics is centered on the importance of the relationship and dialogue through which the four themes of relational environment, embodiment, mutuality, and engagement are fully enacted. Relationships represent a moral space where one enacts not only responsiveness, but also responsibility for oneself and others. Other nursing theorists consider the nurse-patient relationship through a relational lens that takes multiple contexts and relationships into consideration. Doane and Varcoe (2013) argued that there has been little discussion on what is needed to develop and enact the sensitivity and/or the knowledge, capacities and skills required for ethical and responsive nursing relationships within the complexity of the current health care climate. As nurses respond to their obligation to be reflexive and intentional in their care, they may come into a difficult relational space where they are in close proximity with suffering, uncertainty, and/or conflict. Hence, they may find themselves experiencing intense emotional responses—both their own and that of others. Provis and Stack (2004) also noted sensitivity and compassion are often in conflict with organizational directives. This has been noted by multiple researchers who observed nurses find themselves rationing their care in ways that marginalize meaningful relational engagement (Austin, 2011; Nortvedt, 2001). Consequently, Doane and Varcoe (2013) suggest that nurses require a broader understanding of relationships and their significance to ethical nursing practice. This dissertation explores ways in which we look at how individual leaders experience and

navigate moral distress and how they approach its resolution, not only as individuals, but also within highly relational units of work.

The second theoretical element of this research study is the appreciation of relational leadership and what happens to relationships when moral distress is experienced. Multiple researchers since the mid-twentieth century have explored the construct and attributes of relational leadership (Burns, 1978; Greenleaf, 1977; Hollander, 1958; Pless & Maak, 2005; Uhl-Bien, 2006). These scholars have asserted the key to developing relationships was based on three forms of intelligence: emotional, ethical, and relational. *Emotional intelligence* is the ability to recognize one's own and others' feelings and respond appropriately. *Ethical intelligence* is described as understanding not only your own but others' "values, norms, interests, situations, behavior and acting ethically" (Pless & Maak, 2005, p. 12). Finally, *relational intelligence* is the capacity to engage, connect, and interact effectively and respectively with other people and stakeholders (Pless & Maak, 2005). The complexity of health care today requires nurse leaders to understand and leverage these forms of intelligence as healthy and strong relationships are required to deal with the constant change and ethical situations present in health care. Relational leadership describes a way of engaging with one's community of practice wherein the leader holds oneself in relation with, and accountable to, others (McLean, 2014). Uhl-Bien (2006) further noted and described how relational leadership is the space between the leader and follower (p. 1306) with a capacity to extend far and wide within organizations. As such, relational leadership "in its strongest form, functions as a dynamic system embedding leadership, environmental, and organization aspects" (Hunt & Dodge, 2000, p. 448).

As I critically reflect on the theoretical beliefs I bring to this study, it is clear I hold an appreciation for relationships between individuals and an accountability and responsibility for these relationships within the larger socio-political system of an organization. This orientation informs the purpose to capture and understand how nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian health care system. Several scholars have argued that moral distress is an embodied or felt experience impacting the professional on an individual and relational level (Musto et al., 2014; Nathaniel, 2006). When viewed from a relational ethics and leadership lens, this means that individuals are contextual entities who are engaged in relationships surrounded within social, cultural, political, and historical processes (Doane & Varcoe, 2007). Such a point of view illustrates the link and power of moral distress on relationships and its far-reaching effects. The questions explored in this dissertation will inquire about the relational elements of how nurse leaders address (or do not address) moral distress.

Summary of nurse as leader. In Steven Covey's (1999) book *The Seven Habits of Highly Effective People*, he quotes Peter Drucker as saying, 'Management is doing things right, leadership is doing the right thing.' The central tenet of this quote suggests a moral element associated with leadership, which is one of the key elements this study explores. In this section, the nurse as leader was contextualized to offer insight into the nuance of the professional role by providing context for a greater understanding of the phenomenon of moral distress through a leadership lens.

This discussion has provided a brief overview of the historical, political, and social influences that have impacted the profession and delivery of nursing care within Canada and the resultant appearance of moral distress within the scholarship body.

Nursing leaders, across the spectrum of health care, practice in very complex environments rife with conflicts that can and do create moral distress. To understand how and why moral distress impacts nurse leaders, an overview of their roles, responsibilities, and expectations from an ethical and clinical context were presented. As discussed, personal values are part of an individuals' self-concept and, therefore, are held passionately (Gaudine & Thorne, 2000). To state that one is a nurse is to make not only a professional claim, but also a moral one (Austin, 2011). Understanding the connection between self-concept/moral identity and one's professional identity highlights the significance for understanding the ethical link and implications of moral distress within all health care providers, including leaders.

Through this literature review, contemporary scholarship consistently assigned responsibility to health care leaders for creating and maintaining cultures and environments that support nurses yet fail in providing guidance on how to do this when confronted by significant system barriers. Over the years, a burden of responsibility has been placed on leaders pertaining to the resolution of moral distress. Guidelines like the codes of ethics for nurses and health leaders are available as a resource. Having professional values and a code of ethics as nurse leaders is important as it serves as a standard of conduct that should govern individual behaviour. However, a code of ethics cannot guaranty ethical practice which was exemplified by The Mid Staffordshire NHS Foundation Trust's failure to provide safe and quality care to patients, resulting in increased mortality rates.

Finally, a theoretical perspective was disclosed regarding the perceived relevance of relational ethics and leadership. This dissertation explores relational elements of how nurse leaders address (or do not address) moral distress.

Moral Distress: The Concept, Theoretical Evolution, and Contextual Characteristics

Andrew Jameton (1984, 1993) was the philosopher/ethicists who first defined moral distress. In his seminal work, *Nursing Practice: The Ethical Issues*, Jameton (1984) detected incongruencies between nursing stories and experiences about moral dilemmas encountered in the clinical environment and the actual definition of dilemma (Coverston & Lassetter, 2010). In a moral dilemma, one struggles to decide between two or more different courses of action with equal moral credence. Jameton (1993) found that when nurses were asked to discuss moral dilemmas in practice, they shared moral problems for which they knew the morally correct action to take but felt constrained from following their convictions. From this observation Jameton argued the stress experienced in the workplace (hospital) created conflicts that were experienced by three different types of moral and ethical problems: moral uncertainty, moral dilemmas, and moral distress. *Moral uncertainty* is when one is unsure of what the nature of the moral problem involves or which moral principles or values apply: simply stated, something is not quite right and missing. *Moral dilemmas* transpire when two (or more) clear moral principles and a course of action conflict, resulting in not knowing how to act. A classic example of a moral dilemma is when the commitment to promote the patient's best interest and respect of patient autonomy conflicts with what others believe to be in the patient's best interests (Webster & Baylis, 2000). *Moral distress* arises "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6). The Canadian Nurses Association (2008) further contextualizes this definition as "arising in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action to prevent a particular harm" (p. 6). Ultimately, moral distress is a stress reaction within an

individual to a moral conflict that involves conflicting values regarding the morally correct action to take and a feeling of powerlessness over the situation within an environment (Corley, 2002; Sporrong et al., 2007). The category of moral distress was used to distinguish it from the concept of moral stress although the delineation between the two is not always clear in the literature. Vanderheide, Moss, and Lee (2013) asserted in Jameton's view, it is more profound, which is supported by multiple researchers as discussed in the following section.

The key difference between moral distress and the other two types of ethical problems is an inference of a structural institutional dimension where a moral conflict makes the individual feel powerless to challenge the system that is delivering the distress and forcing the individual to do the wrong (Berlinger, 2013). Within the context of the profession of nursing, this creates "painful feelings and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory support, exercise of medical power, institutional policy, or legal limits" (Corley, 2002, p. 6). Jameton's (1984) initial framing of moral distress focused on the institutional and power hierarchies present in organizations that impacted the ability of nurses to practice ethically. These constraints on the moral agency of nurses were noted to be beyond the control of individuals and located in the structures that shape nurses' work.

Theoretical evolution of moral distress. A number of scholars have criticized Jameton's definition for lack of conceptual and theoretical clarity, which has resulted in further conceptual development of moral distress (Burston & Tuckett, 2013; Hamric, 2012; Johnstone & Hutchinson, 2013; McCarthy & Deady, 2008; Musto et al., 2014; Pauly et al., 2009; Rodney, Buckley, et al., 2013; Varcoe, Pauly, Webster, & Storch., 2012). Wilkinson (1987) was one of

the first to build on Jameton's definition with the explicit intention of generating theory about the relationship between moral aspects of nursing practice and the quality of patient care. Acknowledging the importance of institutional constraints, Wilkinson further expanded the operational definition to include the presence of physiologic and psychosocial components in moral distress not mentioned in Jameton's definition. She defined 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''(Wilkson, 1987, p.16). Wilkinson asserted the impact of moral distress was systemic, affecting the entire individual's wholeness as human beings where they (nurses) were unable to act morally due to the nature of the nurse-patient relationship. After interviewing 24 hospital staff nurses, Wilkinson concluded moral distress did not automatically occur because of one particular event; rather, distress required conflict between the nurse's belief system and the elements of the situation. External and internal constraints were identified with Wilkinson generating conceptual categories or indicators of moral distress that included situational, cognitive, feeling, and action dimensions. Wilkinson's research has revealed how the phenomenon embraces both an experience of a moral situation/decision and a perceived inability to act. The experience and constraint in action further triggers an effect where painful feelings and coping behaviors impacted the nurse's wholeness as a human being.

Jameton (1993) elaborated on his initial definition several years later, identifying two different types of moral distress, *initial* and *reactive*. According to Jameton (1993):

> Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and interpersonal conflict with others about values. Reactive distress is distress that people feel when they do not act upon their initial distress. (p. 544)

This work created further clarity and generated additional research concerning contributing factors, perceptions, and responses to moral distress (Burston & Tuckett, 2012; Corley & Minick, 2002; Ferrand et al., 2003; Gutierrez, 2005; Hanna, 2004; Nathaniel, 2002; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Research on contributing factors expanded from Jameton's initial focus on external constraints to include internal constraints and moral action (Beagan & Ells, 2007; Epstein & Hamric, 2009; Jameton, 1984, 1993; Rice et al., 2008; Wilkinson, 1987). In addition, perception and awareness were also found to play an integral role in the development of moral distress. While one individual may experience moral distress regarding an action or inaction taken because of his/her values and judgments, another person may not experience moral distress. Austin, Rankel, Kagan, Bergum, and Lemermeyer (2005) argued the importance of perception and awareness, asserting that receptivity and sensitivity to ethical issues are necessary for moral performance. Individuals must recognize or be aware there is a moral problem.

Researchers have also studied the response reaction to moral distress and have noted the profound and powerful effect it has on individuals. Nathaniel (2002, 2004, 2006) contributed to the operational definition of moral distress by synthesizing the literature and concluding

> moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing. (Nathaniel, 2002, p. 5)

This assertion recognized the depth and embodied response to moral distress through the use of the term *anguish*. Additionally, there is an acknowledgment of the impact of participation in an action that is perceived to be morally wrong. Webster and Baylis (2000) also inferred the long-term and profound personal impact of moral distress on individuals, suggesting that a failure to

act due to perceived constraints may compromise one's personal integrity. Integrity implies a moral standard embracing wholeness and soundness in an uncorrupted condition (Austin et al., 2005). It also represents a coherence between beliefs and actions. Webster and Baylis argued that compromised integrity can cause individuals to trivialize or deny wrongdoing and create a disassociation where the compromise in the work environment is not seen as impacting one's real self. A failure to act, due to perceived constraints, compromises personal integrity injuring a person's sense of moral conscience (Webster & Baylis, 2000). Again, the importance of perception, awareness, and response is profound and far-reaching. Ultimately, individuals may abandon their principles completely and act only for reasons based on fear, expedience, or self-preservation (McCarthy & Deady, 2008). When personal integrity is compromised, it is logical that this will transfer to one's professional integrity and impact the delivery of patient care.

Building on the conceptual framework of Jameton (1984, 1993) and Wilkinson (1987, 1989), significant work has also occurred on creating a scale to measure moral distress and evaluate nursing practice (Corley et al., 2001; Hamric & Blackhall, 2007; Pauly et al., 2009). Corley (1995) was instrumental in developing the Moral Distress Scale (MDS), which was originally designed for critical care and acute care staff nurses. This scale measures the intensity and frequency of the external social and institutional constraints that may lead to moral distress and feelings of anger, frustration, and powerlessness. The instrument revealed evidence of validity and reliability; however, there were concerns echoed regarding the instrument's ability to measure what it claimed (Corley, 1995; Corley et al., 2001). Subsequent revisions occurred with other concepts like role conflict theory, value theory, and consequences of moral distress being integrated into the instrument to enhance its reliability.

Kalvemark et al. (2004) suggest that Jameton's (1984) definition assumed moral distress would not occur if the nurse took action. Kalvemark et al. (2004) recognized that the complexities of health care make the occurrence of moral distress unavoidable. The authors also observed there were several occasions when moral distress occurred independently of the caregiver who knew the right thing to do, but s/he was being constrained by the institution. In a multi-disciplinary study of nurses and other clinical staff, Kalvemark et al. (2004) found health care professionals reported moral distress when they had to make difficult choices between following rules and their conscience. While the professionals acted and made decisions, they still experienced distress related to ethical dimensions in practice (Kalvemark et al., 2004). Kalvemark et al. revised Jameton's definition of moral distress stating it was "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" (pp. 1082–1083). This definition differs from Jameton's in that it does not include the separation of moral dilemmas from moral uncertainty for moral distress to take place. Kalvemark et al. also found that the occurrence of moral distress is not dependent on the position one holds in the workplace hierarchy. This revised definition brings further clarity to individual and structural factors in defining moral distress and also confirms that moral distress is not limited to the clinical bedside in health care (Pauly, Varcoe, & Storch, 2012). Past research has also illustrated that while nurses have found it challenging to enact their professional and ethical values due to constraints within their practice environments, ethical dimensions of the workplace have not been included in this research (Huffman & Rittenmeyer, 2012; Rodney et al., 2002; Storch et al., 2002; Varcoe et al., 2004, 2012). Varcoe et al. (2012a, b) argued if researchers are to account for

individual and structural factors, then the relationship among moral distress, moral agency, and ethical climate must be further explored.

Further criticism came from McCarthy and Deady (2008) who suggest that the nursing discourse on moral distress may intermittently be confusing and counterproductive. Their concerns were two-fold: 1. research on moral distress lacks conceptual clarity and 2. it perpetuates the narrative of moral suffering of nurses and focuses on the nurse as a victim. First, they argued that the concept has been used with various understanding of preconditions for the development of moral distress and focuses too much on the psychological experiences that prompted and/or followed morally challenging situations. This argument is supported by Hanna (2004) who warned that moral distress has become conflated with psychological distress. Hanna went on to argue that moral distress is an act of interior aversion in response to a perceived threat to a known good and to a perceived violation of a person. This can result in a disconnection from one's self and others although the violation may not be expressed (Hanna, 2004). With time and consistency the health care professionals can become desensitized to moral distress and withdraw from the perceived source of harm (Hamric, 2012; Oh & Gastmans, 2015). In a similar discussion Lutzen and colleagues (Lutzen et al., 2003; Lutzen & Kvist, 2012) suggested that the confusion in the definition of moral distress has resulted from the high level of abstraction of the concept. In addition, they argued the limitation of Jameton's explanations of moral distress is based on the insufficient explanation of the "relational elements in the whole process of moral distress" (Lutzen & Kvist, 2012, p. 17). They also asserted that not enough attention had been given to dissecting the ethical component of moral distress so they focused on the moral situations and the possible competing obligations that lead to the ethical conflicts that nurses must address. Based on their qualitative and quantitative research on moral distress and

ethical climate, Pauly and colleagues (Pauly et al., 2012, 2009; Rodney et al., 2002; Storch et al., 2002; Varcoe et al., 2004) concur that research and action on moral distress has been constrained by a lack of conceptual clarity and theoretical confusion concerning the meaning of the concept. Johnstone and Hutchinson (2013) offered a particularly strident critique claiming that “until such inquires are made, the construct of moral distress will at best have only dubious value in nursing ethics discourse” (p. 8). While the conceptual clarity is open for debate and still requires development within the scholarship body, like others (Musto et al., 2014), I believe the concept is highly relevant, especially as it applies to health care leaders.

The second concern with existing research on moral distress expressed by McCarthy and Deady (2008) is the way moral distress is used as a way of understanding the role of nurses in moral decision-making. Several researchers have noted this concern where the concept has focused on nurses’ moral suffering, implying other occupational groups do not suffer from the phenomenon; in addition, the attention paid to the stressful features of moral decision-making indicates that nurses are powerless to do anything about their own stress or the situations that give rise to moral distress (Aita, 2006; Paley, 2004). McCarthy and Deady argued the need for a more critical stance towards moral distress and additional research of the relationship between moral distress and the ethical dimensions of practice that includes philosophical perspectives informing decision-making.

Table 2.1 highlights the sentinel scholars and researchers who have expanded Jameton’s (1984) initial definition of moral distress. While there are critics who argue the concept remains confusing and abstract (Lutzen & Kvist, 2012; McCarthy & Deady, 2008; Pauly et al., 2012; Varcoe et al., 2012b), this table illustrates the conceptual evolution and progression of the definition. The discourse on moral distress has shifted from an initial focus on external sources

of constraint affecting nurses' ability to enact their moral agency to situational and internal constraints.

After reviewing critiques on the theoretical evolution of moral distress, Musto and colleagues (2014) contend there has been an emphasis on psychological distress, negative aspects, and an individualistic focus within research. They summarized glaring gaps that remain including:

1. exploring the moral dimensions of the experience (McCarthy & Deady, 2008);
2. identifying potential learning experiences associated with the experience (Pauly et al., 2012; Webster & Baylis, 2000);
3. understanding the larger socio-political power dynamics that contribute to moral distress (Rodney, Buckley, et al., 2013;Varcoe et al., 2012a, b); and
4. developing effective interventions to prevent and ameliorate moral distress (Hamric, 2012; McCarthy & Deady, 2008; Rodney, Buckley, et al., 2013).

Researchers are just beginning to explore a broader context of the concept by studying the relationship between the structure (organization) and the agent (individual) (Musto et al., 2014). Notwithstanding such progress, it is evident within the current scholarship body that there is a lack of firsthand knowledge of the experience of moral distress from a leadership perspective. Further knowledge is needed through a leadership lens on the obligations creating moral distress, including the impact on relationships and ethical dimensions in practice. With nurse leaders playing such a vital role in health care organizations, this study is relevant due to the impact moral distress has on the individual, job satisfaction, relationships, and patient safety (Beagan & Ells, 2007; Rodney et al., 2006; Storch, 2005).

Table 2.1.

Theoretical Evolution of the Definition of Moral Distress

Table 2.1 Theoretical Evolution of the Definition of Moral Distress
Jameton (1984; 1993)
• Stress in the workplace created conflicts experienced as moral and ethical problems. Identified three types of problems: moral uncertainty, moral dilemmas, and moral distress. • Moral distress occurs when one knows the right thing to do, but institutional constraints make it impossible to pursue the right course of action. • Focus on external constraints such as institutional and power hierarchies that impacts ethical practice in nursing. • Distinguish between 2 types of moral distress: Initial and Reactive Distress
Wilkinson (1987/8)
• Refined the definition to include physiological and affective dimensions of moral distress. • Distinguished between initial and reactive distress
Corley (1995; 2001)
• Developed and validated a Moral Distress Scale (MDS) for measuring levels of moral distress among critical and acute care nurses • Focused on external social and institutional constraints that may lead to moral distress and feelings of anger, frustration, and powerlessness
Webster and Baylis (2000)
• Highlighted the individual and perceived constraints including personal failings that prevent them from acting in ways that compromise their personal integrity. • Outline the negative effects of unresolved moral distress (moral residue) that can linger and impact practice over time.
Lutzen and colleagues (2003, 2005, 2012)
• Research on moral stress explores only the negative psychological aspects (distress) associated with it. Moral stress can be seen as an energizing factor resulting in a satisfactory feeling of accomplishment of professional goals • Identified lack of connection to relational elements • Emphasized a lack of attention in unraveling the ethical component of moral distress focusing on the moral situations and the possible competing obligations that give rise to the ethical conflicts that nurses must address.
Kalvemark and colleagues (2004)
• Provided clarity on both individual and structural factors in defining moral distress • Confirmed moral distress is not dependent on the position held in the workplace hierarchy
Hanna (2004)
• Moral distress involves a perceived violation of the individual that can produce a disconnection from self and others • Argued that the widely accepted understanding of moral distress focuses on psychological experiences that prompt and /or follow morally challenging situations. Warns moral distress has become conflated with psychological distress. • Suggested personal transformation and growth through moral distress
Nathaniel (2002, 2006)
• Moral distress occurs as a result of a dynamic interplay of the nurse's moral outlook, commitment to moral principles that may be either intrinsically incompatible or incompatible in specific situations, relationships with patient's role identification, and perception of imbalance of power or other institutional constraints. • Moral distress is pain and anguish affecting the mind, the body, or relationships that results from a patient care situation where the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, • Inferred the impact and depth of moral distress is an embodied experience
McCarthy and Deady (2008)
• Expressed concern over existing research on moral distress and the way in which it has been used as a means for understanding the role of nurses in moral decision-making
Musto et al. (2014); Rodney et al. (2002);
• Shifted the definition from location of moral distress to a broader context of a relationship between the structure and agent.

Underlying cause. There is no singular cause of moral distress; instead, there are multiple causes, as has been shown in studies over the last 30 years. As discussed, external or

institutional constraints were initially championed as the cause of moral distress with subsequent research linking internal and situational sources to the phenomenon (Beagan & Ells, 2007; Epstein & Hamric, 2009; Jameton, 1984; Rice et al., 2008; Wilkinson, 1987). Specific examples of causal research include

- situations that give rise to moral distress (Cavaliere, Daly, Dowling, & Montgomery, 2010; Corley et al., 2001; Corley, Minick, Elswick, & Jacobs, 2005; Ganz & Berkovitz, 2012; McAndrew et al., 2011; Silen, Svantesson, Kjellstrom, Sidenvall, & Christensson, 2011)
- exposure to negative ethical climates (Hamric & Blackhall, 2007; Mrayyan & Hamaideh, 2009)
- futile care (Cavaliere et al., 2010),
- nursing shortages (Mrayyan & Hamaideh, 2009), and
- uncooperative behaviour of a patient and family member (Ganz & Berkovitz, 2012; Laabs, 2005).

With increasing global interest in moral distress, other frequently cited causes include financial constraints (Aitamma et al., 2010; Corley, 2002; Mitton et al., 2010; Sporrong, Hoglund, & Arnetz, 2006), cultural differences (e.g., disparity in goals/philosophy between health care professionals) (Ganz et al., 2014; Hamric, 2012), conflicting legal and moral objectives, and power differentials among disciplines (Corley, 2002; Rambur, Vallett, Cohen, & Tarule, 2010; Sundin-Huard & Fahy, 1999).

Nursing researchers have identified three primary underlying causes of moral distress: internal constraints, external constraints, and the clinical situation (Corley & Minick, 2002; Hamric, 2012; Hamric & Blackhall, 2007). Figure 2.1 captures these categories, illustrating a

connection among the individual, environment, and the clinical situation. At the center of this connection is the patient. To fully understand the importance of ethics, values, and decision-making in nursing, one must acknowledge the *IS/OUGHT* problem or dynamic that is present (Burston &Tuckett, 2012; Carnavale, 2007; Hamric, 2012). Rodney (2009) asserted nurses suffer moral distress when there is a discrepancy between the care that is provided and that which the nurse perceives ought to be provided. An "ought" statement infers an ethical obligation; where, in contrast, an "is" statement presents an empirical fact (Carnevale, 2007). This is/ought dynamic has been illustrated in Figure 2.1 as a teeter-totter analogy upon which the three primary causes of moral distress rest within the health care environment.

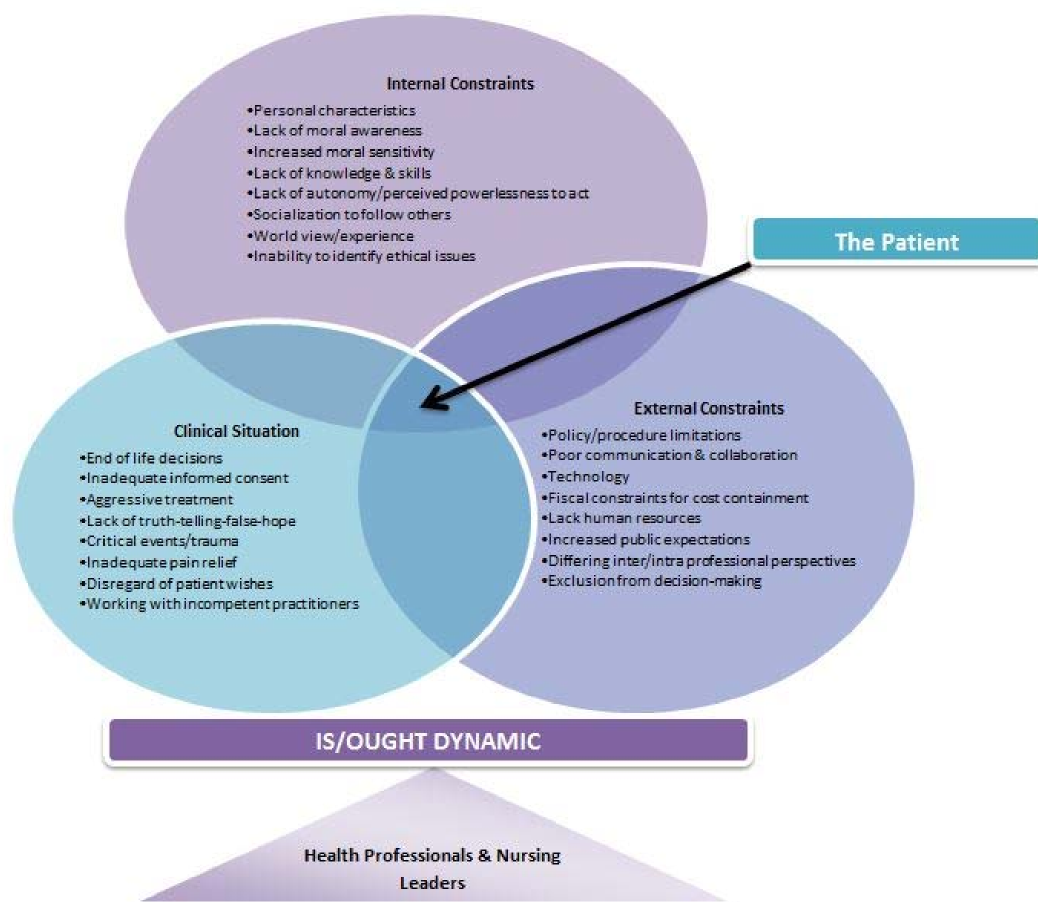

Figure 2.1. Primary underlying causes of moral distress.

Internal constraints refer to personal characteristics such as lack of moral awareness, increased moral sensitivity, lack of knowledge and skills, perceived lack of autonomy and powerlessness to act, socialization to follow others, worldview/experience, and inability or lack of understanding of the full ethical situation (Gutierrez, 2005; Hamric, 2012; Johnstone & Hutchinson, 2013; Kalvemark et al., 2004). These constraints infer a moral or ethical component where, when triggered, can create distress and result in profound consequences for an individual's personal values, integrity, and very well-being.

External constraints may also influence the balance of the teeter-totter and create moral distress for health professionals and leaders. These constraints include environmental factors such as policy/procedure limitations, poor communication and collaboration among team members, impact of technology, fiscal pressure to contain costs, increased workloads, lack of human resources, and increasing public expectations of what health care can and should offer (Corley et al., 2005; Johnstone & Hutchinson, 2013). The exclusion of nurses and leaders in decision-making and differences in opinions based on disparity in professional focus and socialization are examples of external constraints affecting the is/ought dynamic and creating moral distress (Ferrand et al., 2003; Gutierrez, 2005; Hamric & Blackhall, 2007). Although nurse leaders are not as close in proximity to direct patient care, they, too, are vulnerable to moral distress when issues surface where they believe they have failed to protect the patient from harm.

The last primary cause resting on the teeter-totter is the c*linical situation.* The clinical situation commonly references ethical situations within the environment that have been found to generate moral distress among health care professionals and arguably includes nursing leaders. These situations are patient-centered and include controversial end-of-life decisions, inadequate

informed consent, aggressive treatment, lack of truth-telling and false hope, critical events or trauma, inadequate pain relief, disregard for patient wishes, working with incompetent practitioners, and excessive workloads such that quality of care suffers (Hamric, 2012; Hamric, Borchers, & Epstein, 2012; Johnstone & Hutchinson, 2014). These situations may or may not create moral distress within individuals depending on their personal values and interpretation. What is important to understand is that the is/ought dynamic is connected to the clinical situations through internal and external constraints and underlying values and perceptions of health care professionals and nurse leaders. Any one of these three causes of moral distress may tip the teeter-totter in one direction. The key to balancing the teeter-totter is the fulcrum or point that these variables rest upon: the health professional or nurse leader. While the proximity to the clinical situation varies for nurse leaders based on their hierarchal role, it is important to understand and acknowledge that leaders are ultimately responsible for the care provided within the environment and that they can experience moral distress like direct care professionals.

The impact. Documented consequences of unresolved moral distress in acute and critical care nurses have revealed a three-fold response wherein the following are impacted: the individual, the patient, and the organization. As noted in the previous discussion, the link with the patient and the perceived constraint in action can create profound consequences that can quickly extend from a micro to meso or macro level within an organization or community. The impact can be far-reaching and if left unresolved, costly. As such it is important to understand the significance of moral distress and how it links with the well-being of the individual, the implications for patient care, and the negative impact it can have on the organization through professional attrition, ethical climate, and public image (Kalisch, Begeny, & Neumann, 2007; Wilkinson, 1987).

Jameton (1984) was the first to acknowledge that nurses as individuals experience an array of emotions and feelings as a result of moral distress. Reported emotions associated with moral distress include anger (Gutierrez, 2005; Nathaniel, 2006; Wilkinson, 1987, 1989), guilt (Gutierrez, 2005; Nathaniel, 2006; Wilkinson, 1987, 1989), sadness (Gutierrez, 2005; Nathaniel, 2006; Sundin-Haurd & Fahy, 1999), anxiety (Elpern, Covert, & Kleinpell, 2005; Nathaniel, 2006), and depression (Elpern et al., 2005; Nathaniel, 2006; Wilkinson, 1987). Documented feelings resulting from moral distress include frustration (Austin, Bergum, & Goldberg, 2003; Erlen, 2001; Fry, Harvey, Hurley, & Foley, 2002; Gutierrez, 2005; Wilkinson, 1989), powerlessness (Nathaniel, 2006; Sundin-Haurd & Fahy, 1999), hopelessness (Sundin-Haurd & Fahy, 1999), helplessness (Fry et al., 2002), and failure (Brown-Saltzman, 2013). Further psychological reactions include behaviours like crying, loss of confidence, shame (Corley, 2002), self-blame / doubt / disappointment (Kelly, 1998), and loss of self-worth (Elpern et al., 2005; Fry et al., 2002; Kelly, 1998; Wilkinson, 1987). One of the results of these reactions to moral distress is the impact on the individual’s personal relationships and the isolation from the individual’s support system that can result (Berlinger, 2013; Elpern et al., 2005; Wilkinson, 1987). Brown-Saltzman (2013) highlighted how the combined effect of isolation and dismissal play a significant role in accentuating the impact of moral distress that can often lead individuals to become silent. The author argues that without one’s voice, a sense of powerlessness leads to a downward spiral that further inhibits one’s ability to speak out. While Gutierrez (2005) noted that some nurses share their feelings and emotions with family and friends, others withdraw, impacting the individual's personal relationships and further deepening the impact of moral distress on the individual. Consequently, giving voice to ethical concerns acknowledges the experience and assists in alleviating moral distress.

Narratives of moral distress are often centered on shocking incidents with graphic terms used to describe the perceived constraint of being prevented from doing the right thing in a situation where the individual feels like she/he is participating in the harm of another human being (Berlinger, Jennings, & Wolf, 2013). The irony associated with moral distress is that it is "a polite sounding term for a gut-wrenching experience" (Berlinger, 2013, p. 131). Wilkinson (1987) initially identified the psychological disequilibrium and impact to wholeness as human beings; however, Nathaniel (2006) was the first to clearly articulate the "pain or anguish" (p. 5) created by moral distress, allowing for a deeper understanding of how ethically troubling situations impact the mind, body, and relationships of an individual. Nathaniel (2002, 2004, 2006) is among many who have articulated an embodied component to the anguish of moral distress that is evident through the manifestation of physiological reactions such as heart palpitations, diarrhea, pain, headaches, nightmares, sweating, and nausea (Austin et al., 2005; Musto et al., 2014). Musto et al. (2014) assert moral distress begins as a *felt* experience in the body. This *felt* or *embodied* experience represents an "integration of mind, brain and the body, and emotions" (Musto et al., 2014, p. 4). What is exciting about the current research on the embodied experience of moral distress is the suggested link to neuroscience and attachment theory. Musto et al. assert neuroscience may reveal a deeper understanding of moral distress specific to the reciprocity that is present between individuals (agents) and our environment (structure). Asserting that neural growth is experience-dependent based in our surrounding environment and our attachment relationships (Siegel, 2012), Musto et al. (2014) suggested "the quality of relationships in a health care environment may have neurological effects on health care providers as well as the patients/families they serve" (p. 4). They recommended further research in the area of neuroscience, specifically looking at trauma and attachment elements that they

argued provide a greater understanding of how negative relational experiences can have lasting physiological impact. As a health care leader who has experienced moral distress and its psychological and physical effects, I am excited about the acknowledgment of an embodied experience and how social experiences created in the environment can potentially shape neural growth and architecture across the life span (Musto et al., 2014; Seigel, 2012). This conclusion speaks once again to the importance of relationship and the concept of moral distress, especially when exploring possible mitigation strategies or interventions.

While most of the literature views the emotional response to moral distress in a negative context, research has also revealed moral distress can create personal transformation and growth in an individual. The positive side of moral distress was first observed by studying moral suffering and storytelling. Harding (1980) documented how recounting morally distressing situations was found to be important because of the shared learning and knowledge related to quality patient care. Nursing theorist Patricia Benner (1991) also noted the benefit of moral distress, articulating a pragmatic view of morally distressing situations stating, "there is no way to get it right without sometimes getting it wrong" (p. 10). She argues that being open to learning from failure presents a new opportunity for growth. Webster and Baylis (2000) echo the same message, stating the experience of moral distress could provide profound teaching moments, be instructive, and even result in healing as the resolution: moral distress may provide opportunities for reflection and growth in ethical practice. The notion that personal growth and transformation can occur from morally troubling situations is a consistent thread in the literature. Moral distress is further noted to bring an energizing quality to an individual through the satisfaction of accomplishing professional goals (Lutzen et al., 2003) and also allows for enhanced compassionate care and positive emotions of gratitude, acceptance, and love conveyed

through the experience (Rushton et al., 2013). The research on the benefits of moral distress underscores the importance of critical reflection in ethically troubling situations as well as insight into how these experiences can facilitate personal and professional growth, resulting in enhanced quality of patient care. This study will create a further opportunity to enhance the body of scholarship by providing a venue for nursing leaders to share their experiences of moral distress, whether they are negative or positive.

Patients are also impacted by moral distress directly and indirectly through the delivery of nursing care. Direct effects on patients include increased pain, longer hospital stays, and nurses behaving over-solicitously to patients due to the guilt of the circumstances (Corley, 2002). Indirect examples of behavior stemming from moral distress in nurses include distancing themselves from patients, becoming emotionally unavailable, avoiding patients, feeling reluctant to go to work, and leaving the unit or nursing profession altogether (Corley, 1995; Davies et al., 1996; Fenton, 1988; Gutierrez, 2005; Millette, 1994; Redman & Fry, 2000; Wilkinson, 1987). This evidence overwhelmingly supports a direct, and strong link, between patient care and the profound behavioral impact moral distress has on an individual.

Several researchers have further categorized the responses of nurses who have experienced moral distress and its impact on patient care. In a grounded theory study, Nathaniel (2006) interviewed 21 nurses regarding what occurs in morally laden situations in which nurses experienced moral distress. Nurses responded in two different ways: they acted by either making a stand or by giving up. *Making a stand* included refusing to follow physician's orders, breaking the rules, whistle blowing and becoming activists. All of these responses in making a stand involved risk and were rarely successful. *Giving up* was described as going along with an action that was perceived to be wrong, leaving the unit, or leaving the profession. Nurses gave up

because they recognized the futility of making an overt stand, were not prepared or willing to sacrifice themselves, and they driven by the need to protect themselves (Nathaniel, 2006). Hamric and colleagues (Epstein & Hamric, 2009; Hamric 2010) found nurses responded in one of three ways when experiencing moral distress:

1. nurses may withdraw from ethically challenging situations,
2. change positions and/or,
3. continue to raise objections and voice concerns about situations.

It is important to note that both authors' categories involved either withdrawal or advocacy; the difference is Hamric and colleagues' acknowledgment of job satisfaction. The intense feelings and emotions created by moral distress come with a significant cost to the individual, patient, and organization. The residual effects of moral distress within nurses contribute to the quality and quantity of nursing care delivered and have been linked to job dissatisfaction and problems with nurses-patient/nurse-management relationships (Corley, 2002; Erlen, 2001; Hamric, 2002; Jameton, 1984; Nathaniel, 2006; Wilkinson, 1987). Once again this lends support to this dissertation study as residual effects of moral distress experienced by nursing leaders are also explored.

It is apparent from the intense emotions and resulting behaviors that moral distress affects individuals on a personal and professional level. In addition to this moral distress also exerts significant consequences on an individual's work environment. Research in clinical environments has related moral distress to prevalence in the environment (Nathaniel, 2006), staff retention (Corley et al., 2001; Gaudine & Thorne, 2000; Nathaniel, 2006), and low staff morale (Gaudine & Beaton, 2002; Gaudine & Thorne, 2000; Rodney & Starzomski, 1993).

The prevalence of moral distress in the environment is supported by Rushton and Scanlon (1995) who found nearly 50% of nurses have acted against their conscience. Redman and Fry (2000) highlighted the same observation where they found at least one-third of nurses report having experienced moral distress. Research linking the environmental impact of moral distress on nursing retention can be traced back to Wilkinson's (1987) initial study that found 12% of nurses left nursing due to moral distress. Another study of critical care nurses echoed the same takeaway and found 13% of nurses had left nursing positions and a further 5% had left the profession all together because of moral distress (Corley, 1995). What is important to acknowledge is that while some nurses may choose to leave the environment, those who remain in the workplace are still in the environment and surrounded by the history and consequences of the moral distress. These consequences may include poor or disrespectful communication, lack of trust, high turnover rates, abusive behavior, lack of collaboration across disciplines, moral residue, and an erosion of team cohesion (American Association of Critical Care Nurses, 2004; Jameton, 1993; Rushton, 2006). With the personal consequences of moral distress strongly interconnected to the professional and organizational domains, one can see that moral distress is a complex phenomenon that cannot be viewed as an individual concern but more as an organizational concern.

While research has identified common sources of moral distress, not every nurse will experience it when faced with difficult ethical situations. Conditions that cause moral distress will vary among health care professionals just as values and obligations vary among individuals. With regard to frequency and socio-demographic variables, older, more experienced nurses were more likely to experience moral distress (Oh & Gastmans, 2015). In contrast, as nurses grew older, the intensity of moral distress decreased (Corley et al., 2005; Ganz & Berkovitz, 2012).

However, when it specifically came to futile care, older nurses experienced more intense moral distress, and this intensity increased with accumulated years of nursing experience and years of stay in the current position (Rice et al., 2008). This finding links back to the importance of neuroscience where neural growth is purported to be experience-dependent based on the surrounding environment (Musto et al., 2014; Siegel, 2012). Could experience with moral distress decrease the intensity of moral distress? With nursing leaders playing such an important role within health care organizations, regarding the mitigation of moral distress, this lends further support for this study as it explored how leaders of varying years of service navigate and experience moral distress. The findings of this study lend further support to the current work conducted on moral distress and neuroscience.

One final theme associated with the impact of moral distress is the dimension of time. Berlinger (2013) noted that situations that produce moral distress may "fester for some time before the distress begins to erupt and become visible" (p. 135). Brown-Saltzman (2013) also noted that time plays a role in the need for efficiency, in avoidance of the difficult discussions, and in how the experiences attach to one's core and unfold over time. Rushton et al. (2013) pondered the urgency of acting when confronted with an ethical conflict and whether the urgency is dictated by the clinical situation or driven by the overwhelming need to find relief from the painful feelings of moral distress. These findings indicate the importance of time and urgency when considering mitigating strategies for moral distress.

Scholarship has clearly revealed the profound and far-reaching impact that moral distress can have on multiple levels (e.g., patient, family, employee, organization, community, and leader). Emotional responses may vary although the personal consequences of moral distress are strongly interconnected to the professional and organizational domains and are worthy of

significant organizational concern when it comes to supporting and retaining staff and maintaining a positive work culture.

Summary of moral distress. While Jameton (1984) originally defined the concept of moral distress, a number of key scholars have contributed to his conceptual framework further expanding the definition and providing deeper conceptual clarity. Over the years, the discourse on moral distress has shifted from a focus on external sources of constraint impacting the enactment of moral agency to include situational and internal constraints. Contemporary research has now shifted to exploring the relationship between the structure and agent, as reflected in this study.

Factors contributing to moral distress identified in the literature include internal constraints (e.g., individual characteristics), external constraints (e.g., organizational), and situational factors (e.g., unnecessary treatment). Although the experience and causes of moral distress among direct health care professionals are well defined in the literature, research on the experience of moral distress among nursing leaders is noticeably absent. Edmonson (2010) argued the same situations that create moral distress and haunt direct professionals also haunt leaders due to shared fundamental values.

The Structure or Organizational/Ethical Climate

The structure within which the individual is situated, or more specifically the organizational/ethical climate within that structure, also contributes to moral distress. The organizational or work climate construct has been an important unit of analysis for scholars in understanding organizations and organizational behavior (Olson, 1998). The complex socio-political structure of the organizational environment has been shown over the years to influence employees' perceptions, behaviours, and ethical beliefs (Gutierrez, 2005; Hart, 2005;

Hamric & Blackhall, 2007; McDaniel, 1997, 1998; Olsen, 1998). The literature categorizes different work climates (Atabay, Cangarli, & Penbek, 2014; Corley et al., 2005; Olson, 1988; Victor & Cullen, 1988) with the ethical climate as the one most connected to moral distress (Pauly et al., 2009).

The ethical climate represents one dimension of the work environment that reflects the collective behaviour of individuals and is defined as "shared perceptions of what is ethically correct behavior and how ethical issues should be handled in organizations" (Victor & Cullen, 1987, p. 51). Rodney et al. (2006) further contextualized ethical climate for health care as a safe environment with implicit and explicit values that guide health care delivery and shape the environment in which care is delivered. Rodney et al. asserted the safety of patients is connected to the safety of the health care team where both depend on a safe moral climate in which resources and values are in place for safe, competent, and ethical care. Reiser's (1994) research echoed the importance of the delivery of safe ethical care, noting that an ethical environment must also address ethical problems involving patients in ways reflected in how the organization treats staff, sets institutional goals, and manages conflict. Clearly, the ethical climate is an important aspect of the overall organizational climate as it impacts not only the quality of care for the patient, but also for those who are delivering and leading the delivery of care (Huffman & Rittenmeyer, 2012; Musto et al., 2014).

Extensive research has occurred that examines the impact of healthy and unhealthy environments on health care professionals (Corley et al., 2005; Gaudine & Beaton, 2002; Hart, 2005; Laschinger & Finegan, 2005; Lowe, 2006; Lowe & Chan, 2010; Shamian & El-Jardali, 2007; Ulrich et al., 2007). Healthy organizational environments positively impact job satisfaction, staff retention, and the absence of moral distress (Musto et al., 2014). The dark side

is captured in an abundance of research examining the negative impact experienced from organizational restructuring, resource allocation reductions, work environment modifications, increased patient acuity, and a rigid corporate business model that has created significant levels of moral chaos in the nursing profession (Rodney, Buckley, et al., 2013). Scholars have noted that these actions have resulted in a deterioration of nursing work environments in which nurses have experienced tremendous stress as a result of excessive workloads, long hours, reduced quality of care, and unsafe workplaces (Canadian Nurse Advisory Committee, 2002; Duncan et al., 2014; Laschinger et al., 2001; Peter, Macfarlane, & O'Brien-Pallas, 2004). Furthermore, Austin (2012) claimed health care restructuring and cutbacks in Canada (over the last two decades) have been demoralizing and significantly unkind to nursing practice. The author argued "society and those whom it mandates to make choices regarding health care resources are implicated in the moral distress of health professionals" (Austin, 2012, p. 30). Varcoe et al. (2012b) echoed this assertion, suggesting demoralization has resulted from the political economy of Canada based on neo-liberal values emphasizing a business and efficiency model of health care. "Neo-liberal reform, which emphasizes deregulation, market control and competition, has spread beyond economic systems, and permeated political systems. . . . Neo-liberalism has become an ideology that governs daily social relations in a variety of ways that constantly reinforce and reproduce dominant discourses as to the responsibility of individuals and society" (Varcoe et al., 2012b, p. 53). The relevance, according to Varcoe et al. (2012b), is an anticipated increase in moral distress as health care contexts continue to shift where health care resources dwindle and responsibility increases for professionals, including leaders. Ultimately in neo-liberal socio-political environments, those professions rooted in social justice, like nurses

and their leaders, will face increasing tensions and a potential for moral distress (Varcoe et al., 2012b).

Multiple studies have uncovered the impact of the organizational structure on the moral agent. Corley et al. (2005) examined the relationships among moral distress intensity, moral distress frequency, and ethical work environments with nurses on medical/surgical units in two hospitals. They found that moral distress frequency positively correlated with the moral distress intensity and a poor ethical climate. Simply put, moral distress is more likely to occur in poor work environments than in healthy work conditions (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015). Hamric and Blackhall (2007) found that nurses experienced more moral distress than physicians, had more negative perceptions of the ethical climate, and reported lower satisfaction with the quality of care provided. Burston and Tuckett (2012) observed a number of variations in intensity and frequency of moral distress within different environments and concluded that, even though variation existed, moral distress occurs regardless of setting. These research findings reflect the significant influence of the organization on an individual who is a moral agent and the predisposition for moral distress.

Within the research on the environment and moral distress, the well-being of nurses and the impact on the organization, have been studied. Higher stress, emotional exhaustion/illness, job satisfaction, lowered morale, burnout, attrition, and global nursing shortages have been examined (Bell & Breslin, 2008; Burston & Tuckett, 2012; Canadian Nurses Association, 2009; Corley et al., 2005; Gaudine & Beaton, 2002; Hart, 2005; Laschinger et al., 2001, 2008; McDaniel, 1998; Raines, 2000; Shirey, 2006; Shirey et al., 2008). Other studies have specifically examined the impact of workplace environments on nurses' ethical behavior, linking moral distress as a contributing factor to decreased quality of care, workplace safety, and patient

satisfaction (Burston & Tuckett, 2012; Pendry, 2007). There is an unspoken expectation in health organizations of leaders to create and maintain healthy work environments that engage and retain nurses in the workforce (Bell & Breslin, 2008; Storch et al., 2002; Udon & Care, 2011). This expectation lends itself well to the image of a *canary in a mineshaft* (Austin, 2012) especially when scholars have consistently argued the absolute responsibility of leaders in the management of moral distress (Bell & Breslin, 2008; Storch et al., 2013). As an example, one three-year study on how the ethical climate in health care delivery could be improved concluded that nurses in formal leadership roles are fundamental in creating and supporting an ethical climate that allows for open questioning and discussion about perplexing ethical situations (Storch et al., 2009a, b). While I believe this to be important and vital, the irony is that the other constraints imposed within the organizational structure such as organizational restructuring, resource allocation reductions, work environment modifications, increased patient acuity, and a rigid corporate business model work in opposition, create moral distress for leaders. “The ability to sustain healthy work environments for practice, assumes the nurse leader has adequate resources available to handle the complexities of the work environment and meet the demands of an increasingly responsible role” (Shirey et al., 2008, p. 125). The competing organizational initiatives, availability of nursing resources, and the neo-liberal socio-political environment of contemporary health care makes this difficult to achieve.

Universal tensions within hospital environments. While every acute care organization embodies unique cultural and system challenges, Glouberman and Mintzberg (2001) identified universal tensions that are present within hospital organizations. They viewed the health care environment as four different worlds—each with a set of activities, ways of organizing, and mindsets. The four worlds include 1. community (trustees), 2. control (managers), 3. care

(nurses), and 4. cure (physicians). Management/leadership within these four variables is not a homogenous process; each is quite distinct from the others, which leads to a clearer understanding of leadership within each category. Each world holds inherent challenges and, more importantly, an understanding of nurses as leaders.Glouberman and Mintzberg (2001) explained,

> Some people manage primarily *down*, directly into the clinical operations—that is, focusing on the treatment of patients. Others manage *up,* toward those who control and/or fund the institution-state agencies, and insurance companies. In addition, some management is practiced *in,* to units and people under clear control of the institution, while other management is practiced *out,* to those involved with the institution but technically independent of its formal authority. Put these together, . . . and you end up with four quadrants of activity in the hospital. (p. 57)

In effect, the authors argued that the hospital environment results in being not one organization but four, as each part structures itself in an independent way. In this matrix the community (trustees) manages up and out as they are neither directly connected to the hospital organization, nor attached to its hierarchy; leaders manage up and in as they are responsible for the entire institution and are also removed from direct involvement in care; nurses have an in and down focus as they function within a hierarchy of authority and focus on the delivery of patient services; and the physicians operate down and out as they do not report to the hospitals hierarchy. The authors contend that the system ruptures itself along two lines. A horizontal cleavage separates those who operate clinically down into the system from those who work up and out of it, creating the great divide in health care. Underneath are those who respond to professional requirements as well as technological imperatives; above are those sensitive to the needs for fiscal control. A vertical cleavage separates those closely connected to the institution, such as the nurse and the managers on one side, from those involved, but not so formally committed (the physicians and the trustees), on the other. These four quadrants help explain the

many socio-political tensions and challenges within the Canadian health system and organization that all health care providers encounter and as leaders, must navigate. The hypothesis underpinning this study is that it is these tensions that have been unsuccessfully redesigned over the years and have contributed to moral distress in leaders within the health care system.

Summary of the structure of organizational/ethical climate. This discussion has illuminated the relationship between the environment and the moral agent. External constraints within the environment illustrate the complex socio-political elements that individuals and leaders in health care must navigate. While every organization possesses its own unique culture and system challenges, within health care there are universal tensions that predispose individuals for moral distress. The core of this study is to examine those tensions that create moral distress among nursing leaders and the environment within which they work. Musto et al. (2014) argued that one of the new concepts related to the organizational environment morally habitable work environments may be a platform for interventional work in moral distress. Peter et al. (2004) articulated that morally habitable environments are "those that foster recognition, cooperation and the shared benefit of many good as opposed to those that engender oppression, suffering, deception and violence" (p. 358). Musto et al. (2014) proposed, "habitable environments are a space where internal and external constraints to moral agency are minimized, difference is embraced, and moral well-being is promoted through shared understanding of responsibility" (p. 7). This is an exciting concept that supports the argument for further research on the experiences and perceptions of nurse leaders and moral distress.

Leadership Scholarship on Moral Distress in Health Care and Other Industry

To determine if the concept of moral distress was universal or industry specific, a systematic review of the literature using multiple bibliographic databases (PsychINFO,

ABI/Inform, PubMed, Business Source Complete, ERIC, ERC, and Web of Science) was conducted to explore research on moral distress in other industry professions. The rationale was to determine if other industries acknowledged constraints (e.g., internal/external/situational) within organizations, what the impact of these constraints on the work and lives of leaders was, and if there were any key recommendations that could inform this study of nurse leaders. Several observations were made through this critical review of the literature on moral distress.

First, this phenomenon is unique to its association with the health care industry and has been identified as a widespread concern among pharmacists, social workers, psychologists, respiratory therapists, physicians, and registered nurses (Brazil, Kassalainen, Ploeg, & Marshall, 2010; Hamric, 2010; Hamric & Blackhall, 2007; Kalvemark et al., 2004; Pauly et al., 2009; Wilkinson, 1987). The majority of research on moral distress has occurred in acute care nursing and specialty areas like critical care although the phenomenon has been widely studied in a variety of care contexts. Table 2.2 summarizes locations and professions within health care involved in the moral distress research to date.

Table 2.2.

Locations and Professions Involved in Research on Moral Distress

Nursing Specialty Area	Other Health Care Professions
Intensive Care (Critical Care)	Nurse Practitioners
Neonatal Intensive Care	Physicians
Pediatric Intensive Care	Pharmacists
Oncology/Palliative Care	Occupational Therapists
Emergency	Clinical Ethicists
Mental Health	Nursing Faculty/Instructors
Military Nursing	Nursing Students
Acute Care-Medical/Surgical	Psychiatrists
Geriatrics/Long Term Care	Psychology
Neuroscience	Respiratory Therapists
Pediatrics	
Obstetrics/Midwifery	

Significant discussion and analysis of moral distress have occurred in health care research for multiple reasons. First, health care professionals are navigating through an increasingly complex technical, interventional, pharmaceutical, bio-hazardous, and dynamic era of medicine. This has predisposed professionals to an escalation in moral and ethical dilemmas surrounding patient care that include a rising burden of chronic disease management, an aging population, and the need for appropriate resources and equipment for staff to care for patients. Other contributing reasons include health care restructuring and financial resource allocation/scarcity (Corley, 2002; Sporrong et al., 2006), conflicting legal and moral objectives, power differentials between disciplines, and the inherent unspoken social contract between professionals and patients to do no harm (Corley, 2002; Schluter, Winch, Holzhauser, & Henderson, 2008; Sundin-Huard & Fahy, 1999). The thread binding these reasons to the concept of moral distress and the ethical dimension it embraces is the underlying relationship between people. The delivery of health care infers the creation of a relationship between health care professionals and patients. Nurses make up the largest regulated health care provider group in Canada. Representing almost one-half of all health care workers (Laschinger & Fida, 2014), it is not surprising that the profession of nursing has recognized, researched, and acknowledged this phenomenon. In fact, the physical nearness, or proximity, inherent to the nurse-patient relationship of nurses at the clinical bedside 24-hours a day where their work as moral agents caring for other individuals during profound life experiences underscores how this nurse-patient relationship predisposes nurses to this form of occupational stress (Peter & Liaschenko, 2004). The increase in the intensity and complexity of heath care environments explains why moral distress has been the subject of extensive study and analysis within the nursing profession.

Another observation about moral distress within the health care literature is that it is discussed in two overarching thematic groupings. The first theme is on leaders' responsibility to recognize it in their staff/environment and the need to ameliorate or pre-empt the experience. Nurse leaders have been consistently identified in the literature as providing a vital role in creating healthy work environments that must engage and retain nurses in the workforce (Bell & Breslin, 2008; Storch et al., 2002; Udon & Care, 2011). Scholars have argued a leader's response to nurses' concerns about ethical issues is vital to having concerns addressed or dismissed. Furthermore, these discussions have been linked to significant impacts on health care to the well-being of the individual (e.g., burnout, frustrations, emotional and physical exhaustion, and emotional detachment) and the organization (Burston & Tuckett, 2012; Gutierrez, 2005). Dominant workplace consequences of moral distress have included issues of retention and staff shortages, departure from the job or profession, job dissatisfaction, low morale, 'work-a-rounds' in the system, and negative effects on organizational culture extending to broader community relationships (Epstein & Hamric, 2009; Green & Jeffers, 2006; Jakobsen & Sorlie, 2010; Kalvemark et al., 2004; Laabs, 2007; Laschinger et al., 2008; Nathaniel, 2006; Nelson, 2009; Pendry, 2007; Schwarz, 2003;Varcoe et al., 2012a; Zuzelo, 2007).

The second theme echoed in the literature includes recommendations and the need for interventional strategies for nurse leaders to apply when moral distress is identified (American Association of Critical-Care Nurses, 2004a; Burston & Tuckett, 2012; Gaudine et al., 2011; Musto et al., 2014; Ruston, 2006; Rushton & Scanlon, 1995; Storch et al., 2002). These interventions include education to improve ethical situations, support mechanisms, interdisciplinary dialogue, and supportive organizational cultures (Musto et al., 2014). Given the significant empirical and theoretical understanding of moral distress, there is still a strong need

to develop further interventions for health care providers, especially for nurse leaders where the discourse has been relatively non-existent or limited.

The concept of moral distress has been very robust within health care in general; yet there have been gaps noted in the literature regarding varying health care providers. The following discussion will explore the prominent research on moral distress in the leadership culture. A brief overview will then be provided on the findings within the literature on moral distress within other industries.

Scholarship in leadership culture. To date, there has been little acknowledgment or research on the presence of moral distress within leadership roles (Ganz et al., 2014; Gaudine & Beaton, 2002; Mitton et al., 2011; Rodney, Kadyschuk, et al., 2013). After critically reviewing the literature, six seminal research studies are presented that have not only expanded the discussion about moral distress specifically as it applies to leadership, but have also exposed the gap in knowledge regarding moral distress and its impact on those leading the health care system.

Gaudine and Beaton (2002) were among the first to provide a firsthand perspective and voice of the nurse leaders'experiences of moral distress. This study evolved from the work of Gaudine and Thorne (2000), which focused on the ethical conflicts between direct-care nurses and their organizations. Gaudine and Beaton noted that the issue of ethical conflict between leaders and their organizations had not been explored and that "knowledge about such experiences is essential if we are to work towards the resolution of ethical conflicts and towards the mitigation of negative outcome for nurse managers, their organizations, and the nursing profession" (Gaudine & Beaton, 2002, p. 18). This grounded theory study examined the ethical conflict in the workplace and the consequences of unresolved conflict among nurse managers.

Using semi-structured interviews, 15 nurse managers in eastern Canada were interviewed. Four themes of ethical conflict were identified in the data including: voicelessness, where to spend the money, the rights of the individual versus the needs of the organization, and unjust practices on the part of administration and/or organizations. These authors identified factors that mitigated or worsened ethical conflict. The research was criticized for consisting only of interviews and not observation, which is inconsistent with the usual method of grounded theory data collection (Polit & Beck, 2008; Porter, 2010). Regardless of this minor criticism, the study's strength is that it recognized a gap in the literature on moral distress. Hence, one of the main reasons for conducting my research is to further build on this seminal study from over a decade ago and reinforce that moral distress is present within the leadership culture.

A second study associated with the moral distress literature and leaders was a small convenience sample of five nurse managers working in a hospital system in the United States. Shirey et al. (2008) sought to understand what situations contribute to the stress in nurse managers and what decision-making processes they used to address stressful situations in their roles. While this study did not focus on moral distress, of the eight themes identified surrounding nurse manager stress and coping experiences, one theme acknowledged moral distress. The authors reported that four out of five nurse managers reported stress had to do with value conflicts and moral distress where personal pain and anguish occurred. The authors agree on the need to reexamine and reconfigure the nurse leader role, yet they did not to expand on anything more than stress and coping strategies or recommend the need for further exploration of the ethical components creating stress for leaders.

In an unpublished doctoral dissertation, Porter (2010) conducted an interpretive descriptive study on 17 nurse managers across the United States. Telephone interviews were

conducted to examine nurse managers' perceptions of the external constraints on their moral agency, specifically the hospital ethical climate and their experience of moral distress. Attributes of ethical climate were also analyzed to determine if they facilitated or impeded resolution of moral distress. Porter found factors such as administrative policies, communication patterns with physicians, issues related to staff and patients, and multiple job obligations as triggers for moral distress within leaders. Several similarities were noted between the findings of Porter's study and those of Gaudine and Beaton (2002). The first was that nurse managers experience moral distress in response to having to enact policies with which they disagree, including those that are the result of financial restrictions that impact staffing resources and morale. Another commonality included disagreements with enforcing organizational policies related to staff discipline, centralized decision-making, and lack of ethical resources available to nurses within the organization. Porter concluded that the findings from her study supported the need for organizations to explore nurse managers' perceptions of the hospital ethical climate and the ways in which the ethical values of the organization are enacted. Furthermore, she argued hospitals are morally obligated to understand the role complexities of the nurse manager. This current study extends the findings of Porter's work by examining the varying tensions that create moral distress within nurse leaders and the environment in which they work. It explores the experience of moral distress within varying levels of leadership and illuminates their strategies and recommendations to navigate moral distress.

Research conducted by Mitton et al. (2010, 2011) recently ignited interest on moral distress as it applies to the leader. In 2008 Mitton et al. conducted a qualitative study on mid-level managers and senior executives in two health authorities in British Columbia, Canada. From this research, the researchers published two articles on moral distress and health care

managers. The authors sought to determine whether the concept of moral distress was a relevant issue for managers, noting no previous research had examined moral distress in non-clinical managers. Three focus groups (n = 12) and individual interviews (n = 6) with mid-level managers and senior executives in two health authorities were conducted. The authors identify conditions or circumstances in which moral distress occurs, outline the negative consequences of moral distress for leaders' personal well-being, and report potential individual and organizational responses to cope or manage the experience of moral distress (Mitton et al., 2010). They concluded that in mid-and senior-level managers, many of the perceived negative consequences and individual or organizational responses that were expected to potentially alleviate the problem seem to be similar to those reported in the clinical literature (e.g., Pauly et al., 2009; Storch et al., 2009b). The current dissertation study differs from Mitton et al.'s (2010, 2011) in that it has a larger sample size and includes participants across all of Canada in multiple health authorities. Furthermore, participants were clinical leaders in acute care hospital settings.

The aim of Mitton et al.'s (2011) second paper was to determine whether the concept of moral distress is a significant issue for managers. The authors argue that moral distress related to the performance of managerial functions (such as setting priorities and allocating resources) did exist, and that differential implications of moral distress within the administrative hierarchy were present. They found that moral distress is experienced by leaders in implementing decisions with which they do not agree and in situations in which decisions appear to violate obligations to others. They assert these violated principles of honesty, truthfulness, and moral integrity. A criticism of this study was that the authors purposefully sought participants who had previous exposure to a formal priority setting process—in this case, with the program budgeting and marginal analysis (PBMA) framework (Mitton & Donaldson, 2001; Mitton, Peacock, Donaldson,

& Bate, 2003; Peacock et al., 2006). While the research objective was to determine if the concept of moral distress had relevance in terms of key health care managerial functions, the focus of this study was specific to priority setting and resource allocation which differs significantly from my more expansive examination of leadership functions in this current research study. Mitton et al. (2011) concluded that moral distress is a relevant concept for health care managers and found a number of examples of its existence in decision-making relating to priority setting and resource allocation. Their concluding statement acknowledged that this study was a first step in identifying moral distress in health care management and that further research is required to determine how widespread the concept is and what can or even should be done about it. This dissertation study elaborates on Mitton et al.'s (2010, 2011) work by further exploring the larger socio-political dynamics that contribute to moral distress within the environment and examining the interplay between social structures and nurse leaders' enactment of their moral agency. Moral dimensions of their experience are illuminated, and interventional suggestions to address the experience of moral distress is described and interpreted from the data that is specific to nurse leaders.

In contrast to these studies fully supporting the concept of moral distress among leaders, in a cross-sectional survey of 133 Israeli middle nurse managers, Ganz et al. (2014) found that levels of ethical dilemma/moral distress frequency and intensity were found among nurse managers that were lower than those reported among different populations of staff nurses globally, except for those related to administrative issues (Elpern et al., 2005; Kalvemark et al., 2004; Rice et al., 2008). The authors conclude that these results seem consistent among nurses from different countries with varying cultures and health care systems. They argued ethical conflicts might be a product of the work of nursing and not of a specific culture or health care

system. This study highlights the need for research on varying cultures and moral distress as it applies to leadership. This current dissertation contributes to the discussion by illuminating the relationship between the structure and agent within the Canadian culture of health care.

One final study worthy of mentioning is a critical incident study exploring nurse leaders' experiences of working in difficult ethical situations and assisting nurses to cope with moral distress. Pavlish et al. (2016) used the critical incident technique to collect descriptions of ethically complex situations from 100 nurse leaders in California. Responses from participants were qualitatively coded, categorized, and subsequently counted. The results discovered affective, behavioral, cognitive, physical, and relational signs of moral distress. They also noted system-level factors (e.g., work environment, lack of strong ethics resources, and heavy workloads), team conflict, and different perspectives regarding caring for patients as variables percieved to increase the probability of ethical conflict, lending support to the influence of socio-political factors in moral distress. Furthermore, they found that leaders seemed more aware of staff moral distress than their own, suggesting that this could indicate lower stress levels among nurse managers than that which was suggested by Ganz et al. (2014). In Pavlish et al.'s study, nurse leaders identified key actions for addressing moral distress from which the authors created the SUPPORT model to guide nurse leaders in being proactive about moral distress in clinical practice. This model is described by the authors as providing individual, collective, and leadership actions for developing and supporting nurses' moral agency and voice toward a collaborative approach to patient advocacy. This dissertation study is different in that the focus is leader-centric with strategies, lessons, and recommendations directed to assist nurse leaders in their experiences of moral distress.

As I have presented these six prominent research studies on moral distress and leadership, I have commented on how my study extends and elaborates on these results. The overarching significance of this dissertation research is that it provides further insight and understanding of the concept of moral distress from a leadership context. Knowledge related to how leaders interpret, perceive, understand and respond to moral distress enlightens and informs clinical practice by identifying strategies or resources that have helped or hindered leaders in their responses to moral distress. As discussed, previous research has indicated that unaddressed moral distress can result in high employee turnover (Corley, 1995; Corley et al., 2001, 2005), decreased quality of care (Gutierrez, 2005; Wilkinson, 1987), and decreased job satisfaction (Corley, 2002; Elpern et al., 2005) which applies to all organizational employees.

Based on this review, further research on moral distress is needed from a leadership perspective so that policy makers, organizations, researchers, and professional nursing bodies can support and retain leaders—long ago advised by Gaudine and Beaton (2002). The role of nurse leaders is a difficult one, full of complex duties and responsibilities. Baker (2014) argued that with the increasing complexity of the role, many individuals are not opting for managerial positions in health care. Therefore, understanding the experiential perspective of the nurse leader is important as is listening to their recommendations to manage moral distress associated with their role. Enhanced understanding has the potential to reduce stress in leaders and improve role satisfaction fostering high-quality work environments and contributing to positive patient outcomes (Udon & Care, 2011).

Scholarship in other industries. Moral distress is not isolated to health care; on the contrary, the phenomenon is present in other industries. However, different phrases and/or concepts are utilized, and the discourse is not as robust. One narrative highlighted the ethically

troubling situation of a former Canadian soldier General Dallaire. Dallaire (2003) was in charge of a United Nations peacekeeping force in Rwanda in the 1990s. During this time he was unable to get the necessary permission and support to use his troops to prevent a massacre of hundreds of thousands of Rwandans. Austin et al. (2005) recounted Dallaire's profound regret of his moral responsibility to the Rwandans and of his extreme distress at being constrained from responding in the way he believed a military commander and human being should respond. Austin et al. (2005) asserted that while the term moral distress was never attributed to the general's reaction, they believed that this was a classic example of it.

Within law enforcement literature, several articles inferred moral distress although, like the example above, they were not categorized as such. The first article discussed the difference between role morality and personal morality in professional state executioners in the United States. The role of the executioner is to carry out a lethal action against another individual based on a civil judgment on a person's guilt in a crime. In this article Connelly (1997) questioned if it is possible to separate personal and professional values, implying a serious potential conflict between these two variables for professionals involved in administering the death penalty. Connelly (1997) argued contemporary executions are protected by U.S. society values of mechanical and biotechnical tools that create a distance between the executioner and the prisoner. The use of the latest technology and medicalization (e.g., lethal injection) for executions has been embraced to afford the executioners detachment from the end result of their actions. In her critique of this article, Hanna (2004) argued nurses are put at greater risk than executioners when they are dealing with life or death situations as the executioner is shielded from any relationship with the prisoner in contrast to nurses who have intimate contact with their patients. While I agree with Hanna's assertion that the relationship with and proximity to nurses

have with patients can influence the intensity of the experience, I also agree with Connelly's argument that one cannot ignore and undermine the connection of personal and professional morality regardless of any detachment or shielding. In many ways executive leaders are shielded from the patient due to hierarchal levels and organizational responsibilities; this dissertation study will provide an opportunity to explore the relationship/proximity of the patient to the leader and moral distress at varying levels of leadership.

Related concepts frequently discussed in law enforcement literature included stress and burnout and its impact on police officers (Anschel, 2000; J. Brown & Campbell, 1994). Abdollahi (2002) critically examined the literature and found four main categories of police research on stress: 1. intra-interpersonal, 2. occupational, 3. organizational, and 4. consequences of stress on police health. Abdollahi argued the police literature has consistently explored factors causing stress and its resulting impact, from an intra-interpersonal and occupational perspective. Character traits, personality styles, and the dangerousness elements of the work have all been explored. The impact of stress on the physical and psychological health consequences, including job overload and traumatic incidents such as a death of a partner, depression, anxiety, suicide, drug/alcohol abuse, and high rates of divorce, has also been thoroughly researched (Sheehan & Van Hasselt, 2003; Toch, 2002). What is interesting is the acknowledgment by several authors of how police research has remained focused on occupational hazards versus organizational stressors which have been shown to have a greater negative consequence for officers (Abdollahi, 2002; Storch & Panzarella, 1996). These organizational factors included inadequate supervision and poor relationships, input to policy and decision making, role conflict and ambiguity where police are forced to play dual roles as a law enforcer and social worker, and, finally, the conflict between departmental demand and job

objectives (Abdollahi, 2002). The importance of relationship, the relational power imbalances, and constraint within these organizational parameters infer police officers may experience moral distress when organizational practices are not aligned with their own moral identity. Abdollahi offered very pragmatic rudimentary suggestions to mitigate this distress including: (a) understanding the problem, (b) discovering the cause and effect, and (c) implementing solutions. Further research in this area is also advocated by this scholar as well.

Those who work in the field of education also deal with many ethical problems in their professional practice. Like nurses, teachers are moral agents where classroom interactions embody a moral or ethical dimension (Buzzelli & Johnston, 2001; Orland-Barak, 2009; Shapira-Lischchinsky, 2011). As noted, the literature on ethics in education covers an extensive range of topics and dilemmas such as inappropriate allocation of resources, irresponsible colleagues, unethical student behaviour, new technology, and legal requirements (K. Brown & Gillespie, 1999; Campbell, 2000; Husu & Tirri, 2001; Winston & Bahnaman, 2008). Shapira-Lishchinsky (2011) asserted that "when [a] teacher's sense of proper action is constrained by complex factors in educational practice and decisions are made and carried out contrary to the right course, critical incidents which involve ethical conflict and moral distress result" (p. 648). It is this tension between caring for others (e.g., pupils, teachers) and maintaining formality (e.g., rules, educational standards) that sets the foundation for moral distress. Shapira-Lishchinsky (2011) argued that despite the magnitude of ethical dilemmas present in the classroom, teachers are left to their own personal resources without any guidelines from ethical theories and educational sciences to assist them in navigating through these situations. Their research found that many ethical dilemmas stemmed from a lack of confidence in educational abilities and a sense of failure to act properly as those ethical situations recounted by teachers stemmed back to the

beginning of their careers. They ultimately concluded that teachers had difficulty and struggled with ethical dilemmas because they lacked the knowledge of how to deal with them. Shapira-Lishchinsky (2011) commented on the dearth of professional tools to assist teachers and advocated for ethical guidelines to assist in the management of critical ethical situations.

One powerful reference discovered in the education literature discussed an approach for responding to moral distress where reflective practice is advocated to recognize and respond to the moral dimensions of work. K. Brown and Gillespie (1999) discussed how adapted techniques of participatory theater could assist individuals in universities to move past victimization, denial, and numbness—to respond more creatively to circumstances of moral distress. This specific form of theater called The Theater of the Oppressed was created by Augusto Boal, a Brazilian artist and director, who dedicated his life to creating opportunities for people to enliven their capacity to resist oppression. In keeping with his desire of inclusion and empowerment, the audience is encouraged to take part in the scenarios that are played out to create different solutions. K. Brown and Gillespie found this technique to be very helpful in exploring a group's response to moral distress. They stated it is a tool that allows for an appreciation for the interplay of two levels of oppression—one residing in a particular person who acts unjustly and the other located in some dimension of an impersonal organizational structure. They stated one of the valuable lessons taken from this technique is that individual action, no matter how heroic or catalytic, is rarely a route to lasting change in circumstances of moral distress. One person acting alone without a larger social system is too easily reduced to rhetoric without results. This speaks to the importance of relationship and collaboration, which is one of the key learnings from the field of education that may be applied to health care, specifically the mitigation strategies as they relate to moral distress.

The final observations found in the literature are the prevalence of ethical dilemmas and violations in various professional business contexts that have become increasingly common and widely covered in the academic and mainstream literature. Highly publicized cases such as the Dotcom bubble of the 1990s (e.g., WorldCom Inc), the Enron bankruptcy of 2001, and the sub-prime mortgage crisis of 2008 with the collapses of Lehman Brothers have illustrated the significant impact and damage unethical behavior has had on organizations, reputations, and lives within and outside of those organizations including investors, employees, and taxpayers (Prottas, 2013; Rambur et al., 2010; Uhl-Bien & Carsten, 2007; Winston & Bahnaman, 2008). Multiple studies have addressed the conflicting obligations, moral dilemmas, and the development of judgment and decision-making within business ethics education (Cristani & Burato, 2009; Gubbins & Byrne, 2014; Maclagan, 2012; Starcke, Ludwig, & Brand, 2012); however, what is missing is discourse on the experience when one believes one knows how to act but is thwarted by constraints. An exception to this is Uhl-Bien and Carsten's discussion "Being Ethical When the Boss Is Not." In this article, the authors discussed moral distress in the context of subordinate roles and unethical climates. They outlined some reasons why employees might perceive the inability to act in unethical situations that included status differentials, the threat of being terminated, and determination whether or not the employee felt there was an appropriate outlet for reporting wrongdoing. The authors stated that employees would engage in either passive (e.g., remain silent, ignore, accept, comply with orders to take an inappropriate action, and cope with personal feelings of distress) or active (e.g., speaking up, taking a stand, refusing to comply, or leaving the organization) behaviors based on many personal and situational characteristics which they include under the label of powerlessness. They argued organizations must prepare employees in establishing their personal power and developing

upward leadership skills that can better prepare them to take action if faced with unethical behavior of managers or senior leaders. This observation in the business industry transitions well into health care as the underlying message is the importance of organizational support and the power of the nurses/leader's voice in corporate health care.

The business literature illustrated a gap in capturing the voice of employees and leaders, regarding moral distress. In addition, there is also a void in the discourse on solutions for moral dilemmas (Cristani & Burato, 2009; Lurie, & Albin, 2007; Maclagan, 2003). Perry (2011) offered one framework for assessing and resolving ethical dilemmas in business. In this article he explored moral distress, reactions, and mitigation strategies recommended for moral distress by highlighting the myriad of obstacles regarding a right versus wrong business disclosure scenario that created moral distress for business people. The mitigation strategies he recommended included the following:

- paying attention to one's gut (acknowledging cognitive and physical symptoms that something is wrong),
- gathering relevant facts and understanding them engaging one's moral imagination and dialoguing with a trusted colleague,
- critically reviewing each option and clarifying values and priorities to help make the decision including who/what/how will be impacted, and
- act and review by asking what can I personally do to have more support and/or be better prepared in a similar case and what can I do to change/improve the cultural structure of my organization so that similar dilemmas can be avoided in the future?

These mitigation strategies focus on observing one's physical reactions and cognitive skills to navigate morally through difficult situations. Through the use of reflective questions (e.g., What

kind of person would I become if I chose this option and ones similar to it on a continuing basis? Can I look at myself in the mirror and sleep well at night? How would I look if this situation and my decisions were described in the media) and advocation of dialogue with peers. Perry (2011) underscored the importance of personal and professional values.

Summary of leadership scholarship and moral distress in industries. After reviewing the literature in several databases, moral distress is present in other industries; however, it is an undercurrent within the literature. Little was found from other industries that added to a deeper understanding of moral distress in nurse leaders. What was observed was a void in the literature capturing the voice of employees and leaders in other industries as well as mitigation strategies to assist with the resolution of moral distress. Further research is obviously required as moral distress is present and impacts organizational cultures. One last observation specific to the research conducted on leaders and moral distress in health care is that with the exception of the research conducted by Ganz et al. (2014), discourse on moral distress from a leadership context has been grounded in Western culture. Further research internationally is required to further understand the influence of structure on the moral agent and the socio-political dynamics potentially triggering moral distress.

Chapter Summary

Moral distress has been the subject of intense research over the last three decades, specifically within the health care industry and, in particular, to the profession of nursing. While there is an abundance of research on moral distress and front-line nurses, there has been a dearth of information on the impact and experience of moral distress on health care nurse leaders.

This chapter began by contextualizing the nurse as leader to offer insight into the nuance of the professional role and understanding of what the phenomenon of moral distress might

encompass as a leader within health care. In this discussion, a brief overview was provided on the historical, political, and social influences that have influenced the profession and the delivery of nursing care in Canada and the resultant appearance of the phenomenon within the scholarship body. Discussion also ensued on the importance and interconnection of personal and professional values as they relate to the nursing profession and nursing leaders. Furthermore, this discussion traced the evolution of the professional responsibility assigned by the scholars and professional regulating bodies within the Canadian Nursing Association Code of Ethics to nurse leaders for creating and maintaining positive cultures and environments within health care and the shift in responsibility from a leader specific responsibility to a shared one within the nursing profession. This section discussed the importance of professional values and codes of ethics regarding standards of practice and conduct and also provided an important example of how individuals can fail to fulfill their moral obligations due to socio-political influences as exemplified by The Mid Staffordshire Trust failure.

An overview was also provided on the empirical research on the conceptual development and characteristics of moral distress. This discussion not only provided justification for studying moral distress, but also illustrated the evolution of the concept within the literature and established an understanding for the reader. This section also substantiated the profound and far-reaching impact moral distress has not only on individuals, but also on groups and organizations. Several studies were provided that inferred the depth and embodied response to moral distress and the gap within the literature related to nursing leaders. Furthermore, the IS/OUGHT dynamic or teeter-totter analogy illustrated the precarious and unpredictable nature of moral distress and accentuated the importance of relationship among the individual, clinical situation, and organization. The literature indicated all three variables contributed to moral distress;

however, the gap in the literature is in whether this is true for nursing leaders which will be explored in this study. While empirical research has noted the benefits and risks associated with moral distress from front-line nurses, what is missing from the literature is discourse from a leadership context and the relationship between the agent (individual) and structure (organization); it is intended this study will supplement this data.

This chapter also explored the relationship between the structure or organizational/ethical climate and the moral agent (nurse leader). A brief discussion on the influence of the ethical climate within the workplace and the influence it has on individuals was presented. Further discussion occurred on the universal tensions within hospital environments that predispose individuals for moral distress. This highlighted the further need to examine these tensions that create moral distress from a leadership lens that is the subject of this dissertation.

Finally, this literature review has illustrated the prevalence of moral distress in health care as well as its presence in other industries. Discussions are occurring within the literature on ethical dimensions of practice and ethical violations found in other professions. The literature highlighted the complexities of the contemporary work environment, the importance of relationship and relational power, the proximity and reach of moral distress, and the importance of professional tools to help guide individuals through moral distress. Nevertheless, while implying that moral distress is present, the term is not overtly recognized in the current body of scholarship, rendering a preponderance of the voices of leaders silent and eliminating opportunities to share stories and allow readers to understand the unique context of this experience from a leadership context. In addition, while there is a strong echo supporting the need for professional tools to help individuals through moral distress, very few tools or recommendations were discovered in the literature. With this stated, further research is required

as moral distress is not only present in society, but it will continue to occur with increasing frequency in all types of organizations.

In order to document the reality of moral distress in nursing leaders in health care, I will utilize a contemporary methodological approach that is creative and flexible in its design to research the issue, collect data, and interpret meaning. Specifically, I will use interpretive description to capture the participants' experiences and perceptions of moral distress, detailing the context of their unique experiences and creating new knowledge for those in and out of the academic community. The objective of using this method is to fill the void in knowledge by broadening the perspective of the phenomenon and empowering the voices of the leaders who are experiencing moral distress.

Chapter III: Approach to Inquiry, Methodology, and Research Design

This study utilized an interpretive description methodology. Interpretive description (ID), a qualitative research approach, was developed for knowledge building around complex clinical questions arising in the applied health sciences (Thorne, 2008; Thorne et al., 1997; Thorne et al., 2004). As discussed in Chapter II, a noticeable gap existed in the current body of scholarship on moral distress as related to nursing leadership. The purpose of this ID study was to understand the experiences and perceptions of moral distress among nurse leaders as they navigated through morally troubling situations within the Canadian health care system. Aligning with this purpose, the design of the study utilized a variety of data collection methods to explore the following research questions:

1. How do health care nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian health care system?
2. What institutional, professional, and personal approaches and resources do nurse leaders recommend to address moral distress and how does the interpretation of those recommendations help us understand the situation of nurse leaders?
3. What are the implications for nurse leaders' real-world practices that promote the development of a positive quality of personal and professional life for leaders and what are the policy implications for institutional health care environments to diminish conditions that produce moral distress?

A qualitative method of inquiry was chosen for this research to facilitate capturing *backstage* subjective and experiential elements and/or conversations of moral distress amongst nurse leaders by identifying potential themes and patterns shared by my research participants.

The term *backstage* originated in civil rights discourse and implies an exclusive safe space away from the general public where genuine views, thoughts, and/or feelings are disclosed amongst individuals of similar backgrounds or interests (Picca & Feagin, 2007). As a nursing leader in health care, I have witnessed backstage conversations on moral distress and have observed the physical and psychological impact of this stressor in nurse leaders and believe qualitative inquiry, which focuses on the way people make sense of their experiences and the world in which they live (Holloway & Wheeler, 2010), was vital to this study. Within health sciences, qualitative inquiry has allowed researchers to explore questions of meaning, focus on institutional and social practices/processes, identification of barriers and facilitators to change, and discovery of the reasons for success or failure of interventions (Starks & Trinidad, 2007). Starks and Trinidad asserted that choosing a method best suited to the line of inquiry is crucial to obtaining desired results. With ID positioned in an orientation that embodies the "constructed and contextual nature" of a person's experience (Thorne et al., 1997, p. 172), this approach allowed an exploration of the experiential perspectives of nurse leaders while highlighting the importance and impact of moral distress in socio-cultural contexts and everyday life processes.

This chapter describes an overview of the study's research methodology and discloses the theoretical and personal assumptions I brought as a researcher that shaped the design platform of this study. The research study design, sampling approach, process for data collection and the strategies specifically utilized during data analysis are discussed. Finally, the chapter concludes with the ethical considerations utilized during this research study.

Methodology: Interpretive Description

ID is a discipline/practice and action-based methodology. The underlying intent of the method is to explore a phenomenon of disciplinary interest through "excavating, illuminating,

articulating, and disseminating the kind of knowledge that sits somewhere between fact and conjecture" (Thorne, 2008, p. 15). This space between fact and conjecture referenced by Thorne mirrors the very profession of nursing itself, which sits somewhere between objective scientific knowledge and the subjective art of patient care. This method employs an inductive approach in which researchers are encouraged to take the knowledge gained from their studies and experience and subsequently apply it to their practice or disciplinary setting. Developed in the field of nursing by nursing scholars, this genre of research methodology was initially designed to address applied clinical questions within nursing; however, other applied disciplines such as education, community development, and other health professions have found the structure and philosophical rationale for design decisions to be beneficial (Buissink-Smith & McIntosh, 1999; Byrer, 2012; Gillespie, 2002; Hunt, 2011a, 2011b; Khan, 2011; Muscat, 2010; Rostam, 2013; Williams, 2011).

The origin of ID has been linked to a longstanding conflict that has existed over the epistemological paradigms of quantitative and qualitative research (Holloway &Wheeler, 2010; Thorne, 2008). Historically, a positivist biomedical model of quantitative research governed the health sciences. Over the years, traditional qualitative methodologies utilized in health science research were developed within the disciplines of philosophy (phenomenology), anthropology (ethnography), and sociology (grounded theory). The focus of these methodologies addressed theoretical and empirical problems of the social sciences versus the practical problems and concerns of applied disciplines such as those within the nursing profession (Dhamani, 2011; Thorne, 2008; Thorne et al., 2004). Many researchers found they could either conform to the traditional methodological expectations and rules of the social science fields or produce research that had the authenticity for their disciplinary audience—but not both. This conflict resulted in

many health scholars creatively adapting social science methodologies to meet the needs of their applied qualitative inquiry, thus illustrating a genuine need for a recognized applied qualitative research approach that would provide greater understanding of the complex experiential clinical phenomena occurring in health care and eliminate confusion about how qualitative and quantitative findings fit into evidence claims (Thorne, 2008, 2013; Thorne & Sawatzky, 2007). As such, ID requires the researcher to explicitly identify the disciplinary framework and its associated assumptions in order for the audience to access the interior logic that explains the design choices made. ID does not assert that rigid adherence to those earlier traditions produces the best applied research. It honours and acknowledges a tradition in the applied world of making design choices based on the nature of the research question and the intended application of the findings, drawing logic from that to determine whether a design choice does or does not make sense. So it is not prescriptive with technique, but highly prescriptive with logic. It is the researcher's obligation to make explicit the logic that is being used in justifying the design decisions.

From a nursing context, ID captures nurses "ways of knowing" (Thorne, 2013, p. 295) and addresses the "so what" (Thorne, 2008, p. 33) that drives all applied health professions. Utilizing ID to explore moral distress among nurse leaders furthers knowledge about the phenomenon by capturing leader's ways of knowing and addresses the so what associated to leadership practice in health care.

ID was designed to identify patterns and commonalities of experience while maintaining individual variation in meaningful ways that can be applied to individual cases in clinical care (Hunt, 2011a). ID has been applied by researchers in a range of disciplines, exploring a variety of phenomenon in health care including the following:

- care approaches in psychiatric units (Björkdahl, Palmstierna, & Hansebo, 2010),
- kidney failure in diabetic patients (Ravenscroft, 2005),
- hope in people with aphasia (Bright, Kayes, McCann, & McPherson, 2013),
- stigmatization of drug users in the emergency room (Paterson, Hisch, & Andres, 2013),
- nurse responses to moral distress within long-term care (Edwards, McClement, & Read, 2013), and
- Cancer patients' needs and preferences across the cancer journey (Thorne, Taylor, Stevens, Kim-Sing, & Hislop, 2013).

The data represent hundreds of ID studies that have identified professional practice concerns and successfully translated the generated knowledge into an applied practice application and context. The following discussion outlines several of the key characteristics of this research methodology.

Characteristics of ID. Unlike other methodologies, ID is not prescriptive or rigid in its direction for a research study. It is a malleable, open method for researchers to create and design the knowledge-generating research questions and answers of an applied health discipline (Thorne, 2008; Thorne et al., 1997). Described as a framework or design logic model, ID affords the researcher flexibility and significant latitude in the choice and variety of methods to critically explore research questions and get to the essence of the phenomena of interest. The aim is to find a way to generate specific knowledge derived from questions from experiences and clinical ways of knowing (Thorne, 2008). ID specifically addresses research questions generated from clinical or applied practice rather than from theory. It emphasizes the practical implications of the research findings and illustrates the attraction to this methodological approach.

Another characteristic of ID is the flexibility it offers as there are no predetermined limits on data sources. Depending on the question explored and the depth and detail wanted, ID welcomes the use of a variety of sources including reflective interviewing, cross-sectional reporting, and longitudinal follow-up. While nurse researchers have favored interviews and focus groups, other techniques like case studies, hypothetical situations, theoretical propositions, patient records, clinical research, narrative accounts, and practice guidelines can be utilized in ID. Dyadic and triadic interviewing, observing cross-talk and consensus/dispute formation, and collecting group data are all approaches that can also be utilized in creating data that cannot be gleaned from individual interview contexts. This flexibility allows freedom from rules imposed by other methodologies and fosters critical reflection in researchers on what data sources might reveal or conceal. Thorne (2013) argued this is the key to understanding the nature of the data source in relation to the nature of the research question. The flexibility and variability afforded by multiple data sources provide triangulation of the phenomenon under study and contributes to the trustworthiness of the findings generated (Hunt, 2009).

ID embraces an inductive analytic approach to understand clinical or disciplinary phenomena. Findings are driven by the researcher who must comprehend data, synthesize meanings, theorize relationships, and re-contextualize data into findings. A variety of verification strategies can be utilized such as concurrent and constant comparative methods during data collection and analysis where each informs the other in an iterative process (Hunt, 2009; Thorne et al., 2004; Thorne et al., 2010). In the beginning stages of the analysis, the researcher is encouraged to focus on broad questions to capture the overall picture rather than the tiny details of data. Analysis engages rigorous, interpretive, cross-comparison in the context of emerging thematic synthesis (Sandelowski, Trimble, Woodard, & Barroso, 2006). The variety of

techniques that could potentially contribute to a meaningful interpretive description is infinite, limited only by one's creativity, integrity, and professionalism (Thorne, 2013).

By virtue of its reliance on interpretation, ID yields constructed truths rather than facts. The end product of ID study is a "coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable individual variation within them" (Thorne et al., 2004, p. 6). Ultimately, the extent to which the constructed truths are viable and defensible rests with the researcher and how the data is transformed into knowledge that is meaningful and applicable in some new way within the discipline (Thorne et al., 2004).

Credibility. There are several frameworks of quality criteria (e.g., Lincoln & Guba, 1985; Tracy, 2010; Whittemore, Chase, & Mandle, 2001) utilized and generally accepted within the qualitative research community to judge research products as theoretically, epistemologically, and technically sound (Polit & Beck, 2012; Thorne, 2008). Thorne (2014) argued each qualitative methodological tradition grapples with how to authentically evaluate the credibility of a research study and noted ID is no different from the applied methods it embraces. There are four main principles that guide every evaluation of credibility in an ID study including this research study on moral distress.

First, Thorne (2008) argued that all qualitative research is expected to demonstrate *epistemological integrity* which translates to "a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained" (pp. 223–224). What this implies is that during the research process, the researcher must hold an appreciation for the epistemological positions surrounding the research question and create strategies that respect those positions.

The epistemological integrity of this specific study was demonstrated by the critical review of the literature, outlining a thorough review of the scholarship on moral distress and a discussion of my theoretical, professional, methodological, and personal assumptions that influenced my research.

Representative credibility and *interpretive authority* are also vital quality elements. Representative credibility is achieved when the theoretical claims the study purport are consistent with the manner in which the phenomenon under study was sampled (Thorne, 2008). The use of multiple methods to collect and interpret data for an accurate representation of reality, known as triangulation of data sources, is valued as is also recognizing that knowledge exists beyond a single angle of vision or perspective. Regarding *interpretive authority*, Thorne (2008) asserted all knowledge is influenced by perspective; consequently, researchers must ensure interpretations are trustworthy and external to the researcher's bias or experience. Research must also account for reactivity that will occur in the research processes and ensure that systems are built into the study to check interpretations against those of the research participants. To meet these elements of quality in this study, the research questions emerged from the literature after observing a gap in the literature on moral distress specific to nurse leaders. All participants were nurse leaders of varying levels within the setting of an acute care hospital in Canada. Triangulation of data sources occurred through person-to-person interviews, field notes, and reflective journaling. In addition, the interpretation of data went through a check and balance process through review with faculty advisors and a small (four individuals) interdisciplinary consultation group.

The final main principle guiding every evaluation of credibility in ID studies is the presence of *analytic logic*. Within this study, Morse's (1994) taxonomy of cognitive analysis

was used as a framework to illustrate my decision-making as the researcher. An audit trail of coding themes, outlining my cognitive reasoning and research decisions, was maintained to ensure transparency and consistency in the research process.

Further strategies utilized to enhance the credibility of an ID study include *moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness,* and *probable truth*. First, Thorne (2008) argued all health science research should be judged by its *moral defensibility*. The researcher must defend why the knowledge extracted from individuals is required and also be able to articulate the purpose of the knowledge once it is received (Thorne, 2008). My rationale for the need for this research is evidenced through stating the purpose of this study, conducting a thorough literature review, creating a comprehensive research design, and by sharing my theoretical and personal assumptions that inform this study and the analysis of data.

Knowledge produced through ID must also have *disciplinary relevance* and *pragmatic obligations*. This research study was grounded within my disciplinary profession of nursing. I believe this study on moral distress as it applies to nursing leaders is worthy, relevant, and timely, considering the new business and financial values that are driving health care in Canada today. Through my research questions I have generated new knowledge that contributes to the discipline of nursing and leadership on how leaders navigate and respond to moral distress, furthering the understanding of the concept at an individual and larger socio-political level within health care. In regard to *pragmatic obligations*, which assume health research findings will be applied to practice, the design of my research study was initially created to include focus groups to foster a deeper understanding of the concept and ascertain if my findings were representative of the experience. After the first few interviews, based on the significant depth of

emotion and disclosure by participants, I professionally understood that the sensitive and vulnerable nature of the conversations, patient confidentiality, and potential harm (professional risk) to participants presented a significant risk. An interdisciplinary consultation group and faculty advisors were utilized during data collection and analysis to review preliminary findings to ascertain if they were appropriate and consistent within the context of the profession and phenomena. In addition, one of the research questions of the study deliberately looked at recommendations from current leaders regarding strategies and resources that were used to mitigate moral distress in the participants' current practice at the time of the study. These techniques of member checking were employed in a conscious effort to mitigate research bias, based on my practice knowledge, and assisted in my evolution of findings, allowing for the broadest interpretation of meaning possible to illuminate the phenomenon studied.

A fourth element in an assessment of research credibility specific to ID is the *contextual awareness* revealed by the researcher. Thorne (2008) purported the epistemological claims, within which qualitative research methods are based, locate the new knowledge and the society that creates it. She further stated researchers must also understand how their own perspectives are bound by disciplinary perspectives as well as social and historical contexts. Consequently, I acknowledge that my findings are contextual and only represent a moment in time of my participants' experience and their perceived reality. I further acknowledge the self-reflexivity utilized regarding the participants' values and biases but also my own and the influence I had as the researcher and, subsequently, the interpreter of the research findings.

Finally, one must recognize the ambiguous zone of validity within research findings known as *probable truth*. Thorne (2008) asserted that there are no set standards to measure research findings against that account for the notions of truth and representativeness in the real

world. In addition, there are no evaluation standards that can guarantee the validity of research findings. As such, this study does not produce absolute truths but does provide value in gaining insight and understanding of moral distress within nursing leaders. Some kinds of knowledge are the best truths we have until more compelling ones emerge (Thorne, 2008).

While ID is relatively free of rules, evaluative guidelines or principles such as those just discussed are important for research credibility and represent the core values of a craft (Tracy, 2010).

Criticisms. Criticism of ID is present within the literature. Thorne and her colleagues (2004) offered the first when they addressed concerns over blurred distinctions between qualitative approaches and a perceived lack of epistemological and methodological grounding in ID. They proactively argued ID philosophically orients itself with an interpretive naturalistic orientation where an acknowledgment of "the constructed and contextual nature of human experience . . . allows for shared realities" (Thorne et al., 2004, p. 5). They asserted that while ID utilizes a variety of techniques for data collection and analysis, the epistemological foundation of ID differentiates it from inconsistent assumptions characteristic of method slurring. The term *methods slurring* refers to an assorted and irrational use of techniques from incompatible methodological traditions. S. Thorne (personal communication, December 2014) explained, "ID is, in fact, the art of methods slurring. It does not hold with the idea that rigid adherence to those earlier traditions produces the best-applied research." As such the design choice within ID offers flexibility and can blend multiple techniques from other traditional methods—not because researchers cannot follow the traditional methodological rules but because the integrity of the researchers' appreciation for disciplinary knowledge makes that problematic.

The second criticism relates to the dearth and variety of resources contextualizing ID (Hunt, 2011a). Currently, the majority of information on ID methodology has been supplied by Thorne and colleagues (Thorne, 2013; Thorne, 2014; Thorne et al., 1997; Thorne et al., 2004). These authors remain the pre-eminent scholars regarding this qualitative approach and have given it a methodological pedigree, which has allowed for it to proliferate and develop further in the scholarly literature. With no recipe for ID (Thorne et al., 2004), Hunt (2009) asserted that determining how to employ this method can be challenging. As new studies emerge utilizing ID, the variety and quantity of resources are expanding for researchers, illustrating the flexibility and inherent creativity afforded by this method.

Hunt (2009) asserted two further challenges associated with ID. The first links back to the dearth of resources and the resulting deficit of understanding about ID within the academic community. Hunt's critique suggests researchers choosing this methodology understand that they will be exposed to a line of academic questioning regarding how ID relates to other methodologies such as grounded theory, ethnography, and phenomenology. Thorne (2016) asserted "conventional social science methods cannot advance clinical knowledge in quite the manner that the applied health disciplines require" (p. 28). As such, ID offers a different approach; one that offers the opportunity to borrow from other traditional methods to meet the disciplines inquiries within the practice environment. Understanding the linkages of this methodology to other approaches ultimately benefits the researcher.

The second criticism Hunt (2009) raised is that although ID has an interpretive orientation, it is not intended to create new theory. Tension is created when new ideas are uncovered and absent from the literature. Accordingly, researchers must be content with understanding that one of the underlying foundations of ID is that it makes no claims upon truth

and recognize that " interpretive approaches, at best, produce knowledge claims that are inherently particularistic, relativistic, and evolving according to changing circumstances" (Thorne, 2008, p. 206). Furthermore, Hunt stressed that the risk with ID is that researchers may not develop sufficient interpretation and, consequently, limit the usefulness of the research finding for their intended practice application.

Researchers must be aware of these critiques and understand how salient their role is when ID is chosen as a research methodology. The remaining chapter provides a description of my theoretical perspectives and assumptions used to guide this study. A description of the research design, sampling approach, data-collection process, and data analysis of the study then follows. The chapter concludes with a discussion of the ethical considerations used to reduce or prevent harm to the study participants.

Theoretical and Personal Assumptions Scaffolding This Study

ID researchers use a framework or scaffold for their research design. Scaffolding is the initial position from which one builds and creates one's research plan. This architectural structure or foundation of the study includes two critical elements: (a) a literature review and (b) disclosure of preconceived personal assumptions. The first element is the literature review where the researcher/scholar becomes intimately familiar with the current discussions, debates, and knowledge about the phenomenon of interest. This critical review of the literature allows one to develop expertise in the current literature, allowing conclusions to be made about the phenomenon, and also provides insight into who has studied it, how it has been studied, the challenges encountered, and the general conclusions drawn to date (Thorne, 2008). This extensive critical review of empirical and theoretical knowledge was conducted and presented in

Chapter II. That literature review provides an element of the structural framework or scaffold for this research and provided inspiration and motivation for the design of the study.

The second critical element in the scaffolding of an ID study involves articulating what intellectual perspective the researcher brings to the study as well as acknowledging preconceived personal assumption, beliefs, and/or ideas about the phenomenon prior to beginning the research (Thorne, 2008). Understanding and acknowledging the theoretical and practical knowledge the researcher brings to the study and how this knowledge builds the platform for the research design is important due to the pivotal dual role of the researcher (researcher and interpreter). There are four perspectives that shaped the design platform of this dissertation study: disciplinary, theoretical, personal, and methodological perspectives.

Disciplinary perspective. One of ID's guiding elements is the acknowledgment of the impact one's disciplinary or professional perspective has on research. The disciplinary nature of a research study is an important element to consider as a disciplinary curiosity initially determines the research question (Thorne, 2008). Thorne and colleagues (Thorne, Joachim, Paterson, & Canam, 2002) observed how disciplinary orientation, either intentionally or unintentionally, informed many of the qualitative studies they reviewed. Not to consider the implications of a researcher's disciplinary orientation ignores their impact on the study and compromises its quality. Thorne (2008) recommended that discipline be considered "as theory in the sense of understanding the manner in which it will inevitably shape what it is we decide to observe in the field, what we see when we make those observations, and what sense we begin to make of the observations as they progress" (p. 68). Knowing that the disciplinary lens shapes the research design, it is still important for the researcher to remain curious about differences as they search for commonalities (Thorne, 2014).

As a professionally trained registered nurse, in a formal nursing leadership role, the orientation to my research study is primarily grounded within the nursing discipline. I also bring a secondary disciplinary perspective of leadership studies. These perspectives framed my understanding of the concept of moral distress first from a nursing and then a leadership lens as the role of a nurse leader straddles clinical and administrative domains within health care. This was important to acknowledge in order to maintain transparency as I held biases stemming from both roles.

There are several fundamental epistemological common understandings and assumptions that nurses hold across the nursing profession. First, nurses never accept standardization and always assume variation within pattern (Thorne, 2013). "Nursing always and inherently requires knowledge about patterns and themes within people in general so that it can better inform the care of the unique and distinct individual" (Thorne, 2016, p. 28). Second, the nature of nursing knowledge follows a logic model where it is dynamic and cyclical in nature, where it engages, assesses, interprets, plans, acts, and evaluates (Thorne, 2013). This is called the *nursing process,* wherein clinical judgment strikes a balance of epistemology between personal interpretation and research evidence in which critical thinking may play a part to categorize the patient's issue and the course of action. A third understanding is that the nature of nursing knowledge can be complex and disorganized as clinical encounters demand a range of possible variables (Thorne, 2013). Thorne (2013) argued that no matter how much is known about a phenomenon we cannot assume with absolute confidence that we know all there is to know about it and what to do with it. Consequently, it is recommended that the applied interpretive researcher search for commonalities but remain curious and seek differences in variables (Thorne, 2014).

Another understanding within the discipline is that nursing always works with the question of generalities. That is to say “nursing knowledge inherently and explicitly capitalizes on a dialectic interface between the general and the particular” (Thorne, 2014, p. 106). Thorne and Sawatzky (2007) described this assumption by stating “nurses rely on general knowledge not as prescriptive or superordinate truths but rather to expand their repertoire of options for informing the complex considerations that will inevitably be applied in the uniquely individual context of each person” (Thorne, 2014, p. 106). Consequently, the nursing mindset is grounded in the discipline’s interior logic that uses techniques such as categorizations and description as tools toward reasoning rather than as an answer to a question (Thorne, 2014).

These are a few disciplinary understandings and assumptions that nurses bring to research. These frame my understanding of the concept of moral distress and also inform my understanding of the challenges faced by nurse leaders as they experience moral distress. Thorne (2014) clearly articulated that it is the “intimate knowledge of how disciplines thought structure works, and not merely the substantive content of it, that guides a scholar in the kinds of methodological design options that are consistent with and informative to disciplinary knowledge” (p. 107). It is for this reason that researchers who wish to employ ID must have a strong grasp of an applied disciplinary perspective (Thorne, 2014). The design of this study acknowledged these disciplinary understandings of variation, logic, complexity, generalization, categorization, and description that were critical to the structure of this study.

Theoretical perspective. The scaffold design of this study included a theoretical forestructure of relational ethics and leadership that was relevant to this research and concept. This theoretical perspective was discussed and presented in Chapter II and is not repeated here.

Personal perspective. Bentz and Shapiro (1998) stated, "research is always carried out by an individual with a life and a *lifeworld*, a personality, a social context, and various personal and practical challenges and conflicts, all of which affect the research, from the choice of research question or topic through the method used, to the reporting of the project's outcome" (p. 4). Throughout my career, first as a clinical bedside nurse caring for emergency and trauma patients to my current role as a program director of emergency, critical care, and medicine, I have experienced and felt the impact of moral distress physically and emotionally. My personal experience of moral distress has been an embodied experience that has recently been acknowledged in the literature (Musto et al., 2014; Nathaniel, 2006). My positionality, as described in Chapter I, informed my interest in this study and how I chose to study the phenomenon. I believe moral distress transcends the clinical bedside within nursing and is present in leadership roles where the frequency and intensity of the experience vary with each leadership role and its proximity to the delivery of patient care. I also believe that moral distress is an unpredictable experience influenced by personal characteristics, situational contexts, professional responsibilities, environmental variables, and levels of personal, professional, and organizational support.

The research questions and design in this study were influenced by these preconceptions that I embraced about moral distress. I engaged in constant self-reflexivity and transparency throughout the research process to manage the preconceptions I brought from my lifeworld. Core values of honesty and authenticity were maintained so that these preconceptions did not assume more prominence in my analytic process than warranted. To accomplish this, I was introspective about personal biases and how they played a role in the interpretation of findings. Other ways that I bracketed my preconceptions included remaining disciplined, demonstrated by

actively listening to my participants, refraining from filling in the blanks of their stories, and in utilizing probing questions such as, "Tell me more." Journaling and member checking were methods I employed to cross-examine personal predilection or opinions of the research findings, supporting my ability to stay open to new research discoveries.

Methodological perspective. As discussed in this chapter's introductory overview, ID assumes nurse researchers such as myself are not satisfied with description alone but rather want to explore the meanings and explanations that allow for clinical application. The questions nurses are curious about are patient-centered and require knowledge about thinking, feeling, and responding to various conditions (Thorne, 2013). Hence, many ID studies are aimed towards capturing themes and patterns within subjective perceptions that can inform clinical or disciplinary understanding.

While there are no prescriptive steps within ID, there are other underlying philosophical assumptions that guide this research methodology. First, ID aligns itself with a constructivist and interpretive naturalistic perspective which acknowledges the constructed and contextual nature of the human experience (Hunt, 2009; Thorne et al., 1997). Key axioms within the naturalistic inquiry tradition of Lincoln and Guba (1985) provide the epistemological and methodological foundation for ID and include the following (Thorne, 2008; Thorne et al., 2004):

1. Multiple realities are constructed in the context of complex human experience and may be contradictory; thus, reality is complex, contextual, constructed, and ultimately subjective.
2. The inquirer (researcher) and the participant (object of inquiry) are inseparable as they interact and influence one another. The knower and known are inseparable.

3. Theory must emerge from the data rather than from using an a priori theory as it cannot encompass the multiple realities encountered;
4. Studies are conducted in a naturalistic context to maintain the respect, comfort, and ethical rights of all participants;
5. Subjective and experiential knowledge are valued as fundamental sources of clinical insight;
6. Study design capitalizes on human commonalities and individual variance within the area of inquiry;
7. Issues are reflected upon, not bounded by time and context but to those of time and context within which the current expressions are enacted; and
8. Analyses must acknowledge that the socially constructed element to human experience cannot be separated from its essential nature.

These axioms represent the epistemological foundation of ID and the design of this research study. These philosophical underpinnings ensure credibility and legitimacy to ID as a research methodology that has been sought after by researchers in nursing for decades (Thorne et al., 2004).

Research Design

Rather than prescriptive design elements, ID "search[s] out and explore[s] features or elements of a common issue, but will seek to render an understanding of them that honors their inherent complexity" (Thorne, 2008, p. 75). As a result, ID employs a wide range of options for design features that can be employed to assist answering the research question defensibly. This research study utilized the following design features.

Sampling approach. One of the guiding principles for sample size in ID is data saturation (Polit & Beck, 2012; Thorne, 2008). A variety of factors impact data saturation including the scope of the research question, quality of the participants, sensitivity of the phenomenon being studied, depth and richness of the data, and the skills and experience of the researcher (Morse, 2000; Polit & Beck, 2012). In ID, data saturation is important as the sample population must have sufficient heterogeneity to produce in-depth and comprehensive descriptions of how individuals vary in their experience and perspectives (Paterson et al., 2013). The size of the sample may vary, but the obligation is on the researcher to understand what is known about the phenomenon in setting the design for the study. There must also be a concrete appreciation for the relationship between the sample size and the kind of interpretations that the study might want to achieve (Thorne, 2013).

Sample size and justification. To determine sufficient sample size within qualitative research one must consider the nature of the research question, quality of data, breadth of the study, and study design (Burns & Grove, 2001; Sandelowski, 1995). There are several key guiding principles regarding sampling size within ID. First, ID methodology can be conducted on any sample size as long as it is consistent with the research question. ID studies frequently use smaller sample sizes, allowing for a more refined way of capturing the meanings participants assign to their experiences (Polit & Beck, 2012; Thorne, 2008). Second, to project for sample size one must know the following: (a) what knowledge is needed (b) what options are available for getting as close to that knowledge as possible and (c) how inquiry can be enacted to gain knowledge that is respectful and consistent with ethical research guidelines and ethical clinical practice (Holloway & Wheeler, 2010). Finally, an ID study may combine various sampling forms and progress along a sampling continuum "beginning with convenient recruiting to launch

a study, moving into a purposive stance as the dynamics of the recruiting process unfold, and then targeting recruitment for particular instances of certain configurations of a phenomenon in the later phases of data collection" (Thorne, 2014, p. 108).

One of the goals of any research study is to ensure that sample size is sufficiently large enough to provide the rich data that can illuminate patterns and variations in the phenomenon studied and create thematic saturation (Burns & Grove, 2001; Polit & Beck, 2012; Sandelowski, 1995). When no new categories are generated during the iterative process between data collection and data analysis, thematic saturation occurs (Thorne, 2008; Thorne et al., 1997). In this study, I employed convenience, purposeful, and targeted sampling to generate the desired rich research data. Convenience sampling involved using the most readily available people as participants (Polit & Beck, 2012). I initially recruited participants within the Health Authority where I worked and then connected with other provincial authorities through my personal, professional network of colleagues. Purposeful sampling in qualitative research means the researcher intentionally selects individuals who have experienced the phenomenon studied (Creswell & Plano Clark, 2011). A purposeful sample selection for national nurse leader participants was conducted through personal networking within my health authority. Targeted recruitment of individual participants enrolled in the study was initially planned for a focus group although this was not enacted as previously discussed. As I progressed through data collection, I remained cognizant of the principle of data saturation and critically observed when themes and categories in data became repetitive or redundant; whereby, any further data gathered would not significantly contribute to deepening the understanding of the phenomenon (Carnevale, 2002; Polit & Beck, 2012). The number of participants where thematic saturation was achieved in this study was 32.

In summary, three-quarters of the participants (n = 19) were sampled from the province of British Columbia, primarily within my health authority and other authorities in the province. The remaining participants (n = 13) were recruited from various acute care hospitals across Canada. Individual interviews were held with all participants revealing rich information on the experiential experience of moral distress from a nursing leadership context.

Inclusion and exclusion criteria. The inclusion criteria for participants included the following: (a) currently practicing or retired registered nurses; (b) having served as a nurse leader within an acute care hospital in Canada, overseeing at least one acute care program(s)/department(s) (e.g., emergency, critical care, medicine, surgery, obstetrics, and mental health); (c) having worked within an organizational structure of a hospital in Canada with three or more levels of management (chief executive officer, vice president, executive director, director, manager); (d) having worked full-time within the nurse leader role for a minimum of six months; (e) having had span of control of 25 employees or more; (f) having fluency in English; and (g)willing to talk about and reflect on their experiences of moral distress. No specific exclusion criteria were identified.

Procedure for recruitment. Before obtaining the ethics approval, I secured executive leadership and director sponsorship within my Health Authority to endorse organizational support and recruitment of participants for this project. After this sponsorship was obtained and ethics approval secured, nursing leaders working within my Health Authority, in other British Columbia Health Authorities, and across Canada were invited to participate in this study.

The invitation to participate in this research was communicated in three ways: (a) via email through professional networks (Appendix A); (b) through person-to-person meetings, and (c) at leadership meetings within my Health Authority. Purposeful and convenience sampling

were employed to recruit mid-level (managers), senior (directors and executive directors), and executive (vice presidents) management, from various programs (emergency, critical care, medicine, surgery, obstetrics, and mental health), who met the inclusion criteria.

Nurse leaders who expressed interest were sent email specific information about the study (Appendix B), requirements of participants, and a consent form to participate (Appendix C). They were asked to return the signed consent within seven days via email to my university email address. An interview date, time, and location with the participants was arranged and confirmed via email communication. Participants were recruited until the volume and quality of the data set became sufficient to capture the essence of the phenomenon under study.

The plan for recruitment of focus group participants was initially designed to involve target sampling from my sample population (n = 32). Participants who were particularly thoughtful and reflective in their responses during their individual interviews were to be purposefully invited via personal communication or email (Appendix A) to attend a focus group conducted at the end of data collection. The goal of conducting a focus group was to extract greater meaning from the data and validate emerging analytical themes that would best address the research question. Focus group participants would be asked to review the consent form and requirements for the study they previously signed before the initial person-to-person interview began (Appendix C). If a participant attended the focus group with the intention of participating but chose not to sign the consent prior to the focus group, that person would not be included in the group.

All study participants received a $10 gift card as a token of appreciation. Recruitment and data collection were extended from a planned 12-week timeline to a 19 week period due to

participant schedule availability, recruitment, required organizational approval (to participate by national participants), and to ensure data saturation was achieved.

Process for data collection. Multiple data collection techniques were utilized to understand the experiences and perceptions of moral distress within nurse leaders in the Canadian health care system. The specific data collection techniques utilized included semi-structured interviewing of individual participants, reflective journaling, and field notes. Focus groups were excluded. Demographic participant survey information was also collected as a mechanism for documenting the nature of my sample.

Semi-structured individual interviews. Semi-structured interview questions were informed and guided by Jameton's (1984) description of moral distress, what is known about moral distress within the literature, and the research questions of this study. Pre-determined sample trigger questions were prepared for the initial interview that included broad and narrow questions (e.g., Tell me what it is like working as a nursing leader within the Canadian health care system. Have you experienced moral distress within your role as a nurse leader?). These questions were used to facilitate the dialogue and served as a guide during the interview process (Appendix E). To avoid rigidity, an open-ended approach to questions was utilized. Additionally, a responsive interviewing model was employed as new questions evolved with each interview. The goal was to achieve understanding versus breadth and allow the dialogue and interview questions to naturally emerge from individual experiences and perceptions of moral distress; such methodology is consistent with ID (Rubin & Rubin, 2005; Thorne, 2008). To ensure rich dialogue and facilitate an open-ended approach, all pre-determined questions were not used although participants were asked an equal number of questions from each subset of questions during the interview.

All research participants were interviewed either in person or by telephone. Telephone interviews were limited to those participants who were unable to meet in person due to geographical location or scheduling difficulty that would have prevented participation. Telephone and email communication (utilized in recruitment) are not as effective as person-to-person recruitment (Polit & Beck, 2012); however, these strategies were utilized to gain further access to participants (provincially and nationally) and assisted in distribution of study information, consent forms, and confirming interview location, dates, and times. Private interview locations (both within and outside the work environment) were secured to assure a comfortable and confidential environment. A two-hour block of time was requested of the participants through the recruitment email (Appendix A), invitation (Appendix B), and consent form (Appendix C) for the interview to facilitate reflective dialogue.

Individual interviews occurred between April 30 and September 6, 2015, after the appropriate institutional ethics approvals were granted (Fraser Health Research Ethics Board (REB) and Antioch University Institutional Review Board (IRB). Interviews were audio-recorded with consent and then transcribed. I was the only researcher present during the semi-structured interviews. The procedure of the semi-structured interview began with verbalizing appreciation to the participants for involvement in the study, followed by a review of consent process, signature of required documentation to meet ethical standards, and completion of the participant demographic survey (Appendix D). A definition of moral distress and self-disclosure of my interest in this phenomenon, generated from my own clinical practice and academic curiosity, was provided to participants. My interest was shared to build a rapport with participants, fostering a more open, authentic, and enriched dialogue. My self-disclosure also conveyed my own vulnerability as a leader. I shared my voice but refrained from disclosing too

much personal information that could have biased data collection. The participants were informed at the beginning of the interview that they might stop participating at any time if they felt uncomfortable with any of the questions asked. Interview questions followed a broad to narrow scope of questioning related to participants' identification with moral distress within their role, their experiences and perceptions of moral distress, and mitigation strategies (Appendix E).

An audio recording device was used to tape the interviews. Following each interview, I composed supplementary field notes, reflections on my own feelings/experiences, and thematic synthesis. The taped interviews were transcribed verbatim by a transcriptionist, and thematic coding was used to support data-sorting and presentation for analysis. At the conclusion of the interview, participants were thanked and given a $10 honorarium for their time and participation in the study. A participant identification number was assigned after the interview and before transcription to maintain the confidentiality of participants.

Focus groups. Focus groups can stimulate new ideas, create deeper meaning, and reveal certain kinds of social knowledge like beliefs and attitudes that underlie behaviors within the phenomenon (Polit & Beck, 2012; Thorne, 2008). In the initial design of the study, a subset of participants was to be selected for a focus group at the end of all interviews. Consent for participation would be obtained in the initial consent for a person to person interview, but selection would be made based on the degree to which individual interviews were reflective. The rationale for using a focus group in this study was two-fold: (a) to gain deeper meaning of moral distress within a group setting (without breaking the confidence of individual interview data) and (b) to determine if the emerging themes from the data were reflective of the experiential perspective in the work setting.

During the course of the study, I discarded the plan for a focus group. The interview experience began to reveal the intense emotion, vulnerability, and professional risk (harm) involved in enacting this data collection technique. Paired with observing the depth of disclosure of interview differences between convenience and purposeful sampling (i.e. known versus unknown participant), I did not believe moving forward with a focus group would add to the research findings. ID anticipates this as consistent with the flow of reasoning that an applied discipline takes into grappling through a problem. In this case, the threat of harm was significant enough reason to abandon this technique as it was not the right mechanism for adding depth, given the nature of the material I had already collected. A form of *member checking* was performed which is discussed in an upcoming section.

Demographic information. After written consent had been obtained before individual interviews, participants were asked to complete a brief survey prior to any interviews (Appendix D). This information was gathered to describe the study participants so the reader could situate the experiences within the participants' context. Demographic information included nursing experience, education, and leadership experience.

Tracking reflections through journaling and field notes. An important part of my research documentation involved capturing my personal views, reflections, and insights through journaling. Strauss and Corbin (1998) referred to this as *memos* that are "records of analysis, thoughts, interpretations, questions and directions for further data collection" (p. 110). The journal, itself, was an important component of both data and data collection, providing a vehicle for tracking my reflections and observations of evolving conceptualizations and emerging themes and patterns. This tool was used to capture operational information like dates and times of interviews, outlined my assumptions I brought to the research study, chronicled my reflections

and observations from interviews, itemized the emerging themes or links to the literature, and created analytic notes that allowed me to ask increasingly complex questions about what the themes meant for participants.

The act of engaging in journaling is an important task of a researcher as it allows for documentation of subjective and objective information that occurs during the research process and becomes a core element of informing one's inductive analytic process (Thorne, 2008). This journal carried my field notes of observations of participants during interviews, my questions, and ongoing analytical notes. Field notes were taken during and following interviews to track experiences that could not be captured on audio recording (i.e., non-verbal behaviours). Ultimately, the journal and notes facilitated a process of critical self-reflection on my biases, reflections of my feelings/emotions, theoretical predispositions, preferences, and overall inquiry (Schwandt, 2007). Table 3.1 captures the structural design elements and examples of inductive/analytical questions I utilized in my journal and throughout the research process.

Table 3.1.

Journal Structure and Questions

Table 3.1 Journal Structure & Questions
Structural Design Elements • Detailed dates and times of interviews • Outlined personal assumptions I brought to the research study • Chronicled reflections and observations from interviews • Flagged poignant accounts within the data • Highlighted themes with color post interview • Recorded observations of participants before, during, and after interview • Summarized each interview • Itemized and reflected on emerging themes or links to the literature • Created analytic notes allowing increasingly complex questions to form and be asked of participants about what the themes meant. • Reviewed interviews frequently and made comparison notes looking for themes
Examples of inductive/analytic questions • Why is this here? • Why not something else? • What does it mean? • I wonder if....

Examples of inductive/analytic questions (cont'd)

- Have I seen other cases?
- What are the ways of...
- What pieces of the puzzle am I seeing?
- What am I not seeing?
- What else might there be to see and how would I know that?
- What are the experiences of...
- What ideas are starting to take shape that will do justice to my research question?
- What is happening here?
- What is the story telling me?
- Things I learned that surprised me?
- Why is this different / similar?
- How are these things related?

Data analysis. According to Thorne (2008), data analysis is "hard work. . . generating new constructions out of the data. . . . [and] unquestionably the most painfully difficult and yet the most essential element in what constitutes a credible ID study" (p. 142). It is a process that demands astute questioning, active observation, linking pieces of data into categories about the phenomenon and recognizing the significant from the insignificant (Morse, 1994). The process of data analysis in this study was informed by ID method. ID does not provide a step-by-step process for data analysis. Rather, analysis is characterized by a balance among broad prescriptiveness, creativity, and flexibility (Thorne et al., 2004). One of the underpinnings of ID is that it emphasizes that research findings/results should have the potential to guide disciplinary knowledge and be relevant to the applied practice context. Another feature of this method within data analysis is to find patterns or themes within descriptions of a phenomenon and then interpret what explains the resolution or continuation of that phenomenon (Thorne, 2008). Qualitative researchers generate large amounts of data composed of narratives from interviews, field notes and documents, and a variety of memos regarding the phenomenon under study (Bryman, 2008). Inherently, this highlights the importance of stewardship (and the need for organization) in the data analysis process. In ID the responsibility and accountability rests with the researcher who drives the interpretation by

determining what constitutes data, synthesizing meaning, theorizing relationships, and recontextualizing data into findings (Morse, 1994; Thorne et al., 2004). Qualitative researchers must take risks and commit to making interpretations in the data analysis process (Sandelowski & Barroso, 2002); however, researchers are reminded of the importance of taking ownership of the interpretations and the moral responsibility they have in their role as interpreter and in their research findings (Emden, Hancock, Schubert, & Darbyshire, 2001; Thorne et al., 2004).

Data collection and analysis occur concurrently in ID, each informing the other in an iterative process. Figure 3.1 outlines the concurrent and iterative strategy to the analysis, rationale, and cognitive process used in this study. This strategy allows another researcher to follow the cognitive development of research decisions as they evolved, ensuring transparency and consistency in process. While data management of coding, sorting, and organizing is important, Thorne et al. (2004) argued the key is the process of intellectual inquiry. As such, Thorne encourages the researcher to constantly explore questions (e..g., Why is this here? Why not something else? What does it mean?) (see Table 3.1) throughout the data collection and analysis process. This allowed me to consider a range of possibilities before interpretive conclusions were completed. The following discussion begins with the strategies used specifically for this study, followed by a description of the cognitive process of analysis.

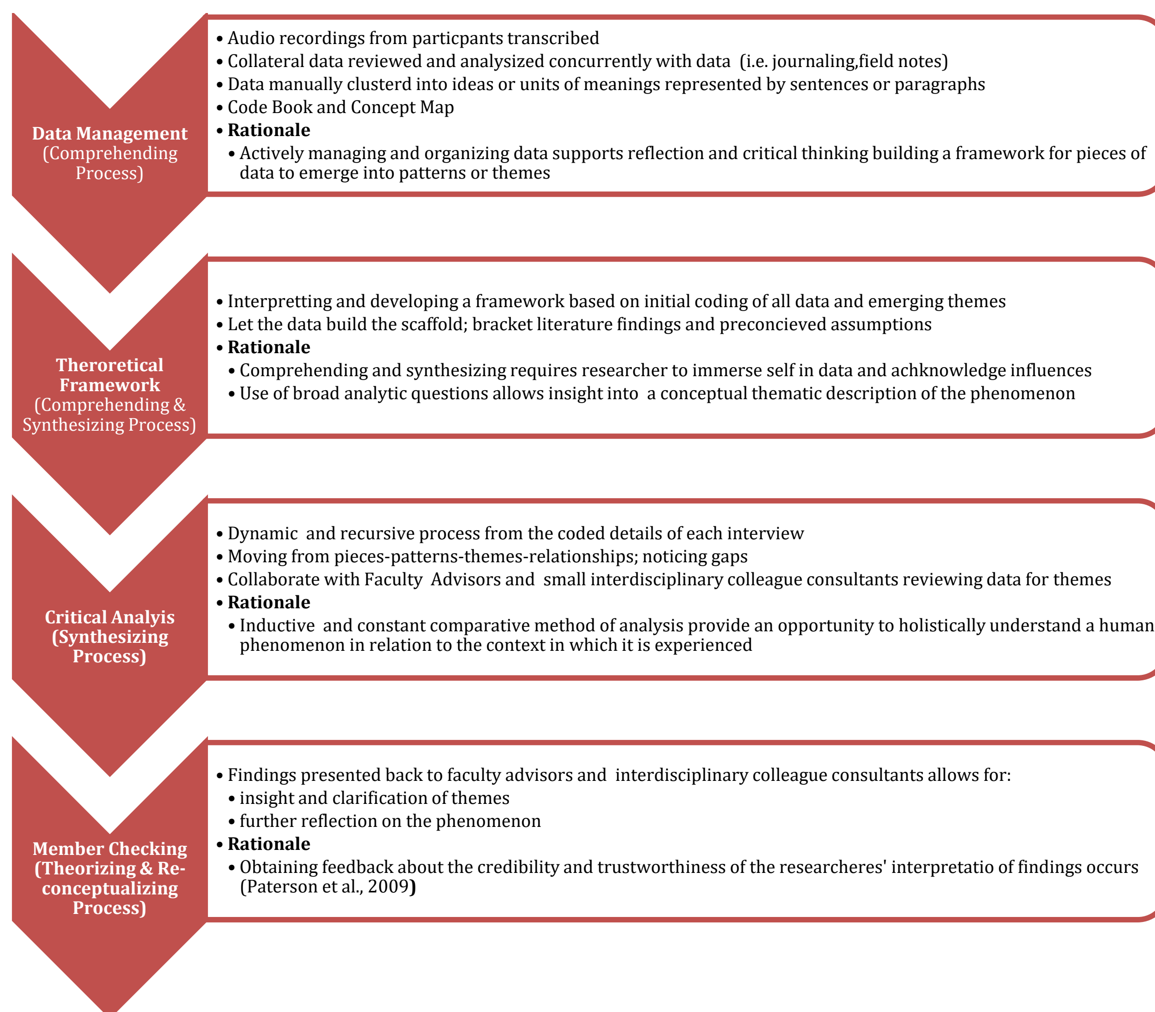

Figure 3.1. Concurrent and iterative data collection and analysis approach from "Emerging from the data: The cognitive process of analysis in qualitative inquiry," by J. M. Morse, 1994, In J.M. Morse (Ed), Critical issues in qualitative research methods (pp. 23-43). Thousand Oaks, CA: Sage.

Data management (comprehending process). During the data management stage, the goal was to learn as much as possible about the participants' experiences and perspectives to make sense of the data. Care was taken to make accurate records including audio recordings, field notes, and reflexive journaling. Actively managing and organizing data supported further reflection and critical thinking and allowed for patterns and pieces of data to emerge into themes.

The process of data analysis began with data collection and the first interview conducted. The audio-recordings of each interview were transcribed by a professional transcriptionist upon completion of the interview. Between receipt of the transcription and analysis, I engaged in

reflective journaling and a completed a synopsis of my field notes. Journaling was an important component of data collection, data management, and data in and of itself. It allowed for responsive interaction between data collection and analysis, a refinement of the data collection technique, and inquiry as new insights were discovered as ongoing collection occurred. The text in my journal contributed to the dataset in terms of capturing my observations about participants and allowed for critical analysis of my thoughts, shaping the data and the emerging findings. Other collateral data reviewed were field notes taken during the interview that supplemented my understanding of the experience of moral distress within nurse leaders. These focused on first and third person perspectives including my observations of the participant's verbal and non-verbal cues and comfort level during the interviews. I also consulted with the participants on meanings I observed during the interview to gain their interpretation of the observation.

I reviewed the transcript and listened to the audio recording for accuracy. This was done in conjunction with reviewing the journal and field notes to gain a contextual understanding of the phenomenon. The data was scrutinized for clusters of ideas or patterns from the research participants. These clusters were recorded in a separate code book to assist with further development of categories and themes. A spreadsheet was utilized in this code book that extracted and condensed units of meaning (e.g., clusters of ideas, thoughts, and poignant examples) from the raw data. One axis of the spreadsheet represented units of meaning, sub-themes, and main themes (X-axis) with the other axis capturing the participants' reflection (Y-axis). This facilitated the process of data analysis by illustrating coding, comparison, and contrasting processes representing the information gleaned from the interview process (Table 3.2). This tool was extremely helpful as it was very easy to drift into excessive and precise coding due to the interesting and rich data. There were several instances where this

occurred which initially prevented a "broad angle of vision" from developing (Thorne, 2008, p. 147) and created immense feelings of being overwhelmed. Refocusing on the spreadsheet assisted in organizing the data but also allowed me to see beyond the codes and engage in inductive analytic processes to make sense of the underlying themes found within this study.

Table 3.2.

Sample Spreadsheet for Condensed Meaning Units, Sub-themes, and Main Themes

Condensed Meaning Units from Individual Participants	Sub-themes	Main Themes
I.E. My heart started to race and I felt sick to my stomach (P 22)	Physical reaction to experience	Response to moral distress
I was so frustrated (P4)	Emotional reaction to experience	

Theoretical framework (comprehending and synthesizing process). The second strategy focused on interpreting and developing a theoretical scaffold based on the initial coding completed through data management. My intent was to foster the inductive analysis that builds the eventual conceptual structuring of my findings from the data. While the data created this scaffold, the empirical and theoretical literature reviewed for this study and my preconceived personal assumptions informed this study. I had to bracket these influences during the study to avoid being incapable of seeing anything other than these preconceptions in the data.

Comprehending and seeing the patterns and themes that made up the theoretical scaffold required that I completely immersed myself in the data to gain a deep understanding. This involved a significant amount of sifting and sorting to determine what themes were present. Broad analytic questions were used such as "What am I seeing here?," "What is happening here?," and "What am I learning about this?" to foster inductive analysis (see Table 3.1). Through this analytic questioning, I became aware of the important aspects of the data set and

began to conceptualize how parts relate through critical analysis forming the theoretical scaffold of this research (Morrow, 2005).

Critical analysis (synthesis process). Each transcript was studied on multiple occasions to reveal data (thoughts, examples, clusters of ideas) relevant to understanding the experiential perspectives of moral distress in nursing leaders and the mitigation strategies they utilized within their work environment. This was a dynamic and recursive process of moving in and out, between, and back and forth, from identified details of each interview. As noted, in ID, micro-coding is not encouraged as it prevents the researcher from seeing and developing the larger picture of the phenomenon. As I critically reviewed each transcript, I flagged with a colored highlighter significant units of meaning that related to experiences with, perceptions about, and navigation of moral distress. These included key words, phrases ideas, or poignant examples gleaned from the interviews. Color coding allowed visualization within and across participants as well as identification of any similarities or differences within the data. These units of meaning were documented on the data source spreadsheet in my code book (Table 3.2). This strategy did not follow a linear path as there were periods of immersion and distance from the data to reflect on the patterns emerging, the relationships among those patterns, and the meanings/findings within those patterns and relationships.

I consulted with faculty advisors and interdisciplinary colleague consultants (four individuals) to discuss and review data analysis and the emerging themes evolving from the data. I provided the units of meaning found in the raw data that I synthesized and then asked for their interpretation of the same data to compare/contrast conceptualizations of themes. This continued through the study's data collection and analysis process. The interdisciplinary colleague consultants worked within health care in Canada and the United States. The consultants included

a senior human resource consultant, a health care leader responsible for strategic initiatives and clinical optimization, a senior project manager consultant, and an executive nursing leader. Each was given a $100 honorarium for consultation. Research data remained confidential as the only identifier the consultants were exposed to was a participant identification number.

Synthesizing was also enacted through the use of concept mapping. Through this technique relationships and gaps between themes were examined by visualizing the links among the themes. Main themes were organized around the research question to which they pertained. Several concept maps were utilized and reviewed with faculty advisors and my consultants through data collection and analysis to facilitate a process of cross-comparison of concepts that emerged from the data. The benefit of inductive analysis and constant comparative method of analysis found in ID provided an opportunity to holistically understand a human phenomenon in relation to the context in which it was experienced.

The cognitive process of analysis. The analysis phase in ID involves moving "from pieces to patterns" by attending to the inter-relationships among the coded data (Thorne, 2008, p. 142). With this stated, the obvious question to a neophyte researcher is how does one process the data? Morse (1994) stated that the actual process of data analysis within qualitative research remains poorly described with "the actual cognitive processes inherent in analysis, processes of synthesization that led to the aggregation of categories, strategies for linking categories, and decisions and processes of falsification and confirmation in theory development remain[ing] mysterious to all but the qualitative researcher" (p. 24). Thorne (2008) advocated the use of Morse's (1994) four sequential cognitive processes—comprehending, synthesizing, theorizing, and re-contextualizing—as a framework to assist in the analysis and conceptualization that ID requires. I found this to be very helpful during the analysis of this study.

The first process is comprehension where the researcher is to "learn everything there is to know about the setting, the culture, the study topic, and participants" (Morse, 1994, p. 26). To achieve this, a solid comprehension of the scholarship body must be achieved, and this knowledge must be kept in abeyance and separate from the data to prevent contamination of the researcher's perspective (Morse, 1994). This provides the researcher the opportunity of comparison and ability to recognize new themes or patterns in the data. For optimal comprehension, Morse asserted that the researcher must enter the setting as a stranger and be capable of passive learning, non-judgmental, and have participants willing to share their experiences with the researcher. Morse also argued that familiarity with the setting or acquaintances with the participants dulled the researcher's ability to view the setting in a critical fashion. Ultimately, comprehension spans the continuum of data collection through data analysis where processes of coding and note-making "generate an endless set of new questions that uncover deeper layers of understanding about the phenomenon" (Thorne, 2008, p. 165). Comprehension is reached when the researcher has heard everything and can identify patterns of experience and predict their outcome.

I utilized multiple techniques to reach the fullest comprehension. The first and most important step was beginning with the literature review. After completing this extensive and thorough review, I was confident in my knowledge base of moral distress. Throughout the study, I would routinely review the scholarship for new and relevant discourse on the topic. While I was familiar with the setting and topic of this research study, I took precautions to avoid threats to validity and political and social conflicts that could have occurred (Morse, 1994). I bracketed or set aside my own preconceptions of moral distress by actively listening to the information that was provided. To facilitate comprehension I audio taped the interviews, completed journal

entries, and engaged in analytic memoing and field note taking to support this action. Also, I engaged with my data by reading the verbatim text and comparing it to the audio tape for transcription errors. I completed this for each interview, multiple times. This was an iterative and recursive process where I took pieces of data and explored for patterns through comparative analysis as I reached participant saturation. Reflective journaling was completed after each interview where observations, thoughts, patterns, and further questions were noted for further exploration in an attempt to uncover themes that were beginning to emerge.

Synthesizing, the second process of cognitive analysis, is where stories, experiences, or cases are blended to describe typical patterns of behavior or response within the data. Morse (1994) noted this is a filtering process that eliminates the "insignificant noise" from the aggregate stories leaving only the common but important features. Synthesis is reached when the researcher can confidently provide descriptions and examples of how people act, relate, and/or respond to the phenomenon, illustrating generalization (Morse, 1994). Within this study, I sifted through the data and filtered the information from units of meaning to patterns and then to main themes. I utilized concept mapping to assist in the synthesizing process to visualize possible relationships across participants, allowing pieces of data to move into patterns.

Theorizing is the next process in the cognitive analysis framework. This is described as the constant development and manipulation of theoretical schemes until the best one is developed (Morse, 1994). Ultimately, it is the best guess at the meaning of data emerging from the study. Analytic techniques focused on asking one of ID's guiding questions during this process: "What might this mean?" (Thorne, 2008, p. 49). New questions emerged from the data that furthered the understanding of the phenomenon. I incorporated these questions into subsequent interviews.

The final process is re-contextualization where the development of the emerging theory is applicable to other settings and populations to which the research may be applied (Morse, 1994). This process brings theory back to the applied practical discipline and acknowledges the newly generated knowledge (Thorne, 2008). The goal of this process is to place the results in the context of established knowledge, to identify clear findings that support established knowledge/theory, and to claim new contributions to the scholarship body (Morse, 1994).

Morse's (1994) taxonomy of cognitive operations provided a framework and organization for my analytic thought process. It also provided insight into the rigor I employed during analysis that is important as the researcher drives the interpretive process (Morse, 1994; Thorne et al., 2004).

Landmines. Throughout the process of analysis, I was cognizant of the traps or landmines in inductive analysis that are associated with ID (Thorne, 2008). I was able to avoid premature closure (i.e., stopping at the first a-ha moment, creating artificial coherence among data pieces, or fitting data too quickly into themes); misinterpreting frequency (i.e., linking frequency with importance, assuming something happens often even if you have only observed it once, and assuming that because you haven't seen something, it doesn't exist); and over-inscription of self (i.e. becoming an important part of the story, self-absorbed), all common missteps. Regardless of knowing about these landmines, I openly admit that I stepped on a few of them specifically related to me as a researcher. The first was becoming overwhelmed by the enormity of the task and complexities of analysis, and the second was self-criticism of the analysis of the study. Each of these described hazards can lead to a misrepresentation of meaning and can compromise the credibility of the findings (Thorne, 2008). With this stated, I am confident through the

safeguards of follow-up conversations with participants, faculty and inter-disciplinary colleague member checks that I avoided researcher bias in interpretation.

Member checking. The final strategy of this study was member checking. Conventional member checking involves bringing the researcher's observation and tentative interpretations back to the participants by sharing what has been learned and offering an opportunity to reflect on the extent to which the themes fit with the experience and phenomenon (Bjorkdahl et al., 2010; Smith, Hale, Olson, Baxter, & Schneiders, 2013; Thorne, 2008). As discussed, my original scaffold of the research design had to be modified. To achieve a similar experience as a conventional member check, I had follow-up conversations after the interviews with selected participants to share my evolving observations and tentative interpretations and offer an opportunity to reflect on these and comment if these mirrored their experiences. I also engaged my faculty advisors and inter-disciplinary colleagues throughout data collection and analysis in a similar fashion that further gave shape to my evolving analysis and understanding of the findings of moral distress in nursing leaders.

Ethical Considerations

Prior to engaging participants in this research, approval was obtained from Fraser Health's REB and Antioch University's IRB. Included in these applications were email and written invitations to participate in the study (Appendices A and B), Informed Consent Forms (Appendix C), a participant demographic survey (Appendix D), and the proposed individual interview and focus group question templates (Appendices E and F) that were used for each participant.

Written and verbal consent were required prior to conducting interviews with any study participant. Consent was for a semi-structured interview with the possibility of a follow-up

focus group. This process incorporated an informed consent process where consent was obtained for audio recording the interviews and focus group meetings, transcription of audio recordings, and reporting the patterns and themes of information provided. This consent process included an agreement to both primary and secondary analysis of data as new themes emerged from the data collection. The intent of the consent process was to explain the research study, purpose, and background. Participants were informed of the voluntary nature of their participation in the study and the two phases of the research. The first phase was an individual interview that was conducted in person or by telephone. The second phase was to involve purposeful and targeted sampling from the interview group participants to participate in a focus group. Participants in the focus group would be responsible for a signed agreement to their confidence regarding the disclosure of any information outside of the interview setting. All participants were informed that they had the right to withdraw from the study at any time without prejudice with the guarantee that no harm was expected (e.g., participation would not affect employment), all of which was outlined in the consent form. Participants were advised that all information would be held in secure confidence although research records identifying them could be inspected in the presence of the Investigator by representatives of Antioch University or the Fraser Health Research Ethics Board for the purpose of monitoring the research. Consent also depended on the participants' understanding that they had the right not to answer a question and/or stop audio recording of information at any time.

Confidentiality of the participants and their information was maintained in multiple ways. First, at no time were any specific comments attributed to any individual unless specific agreement had been obtained beforehand. Second, no personal identifiers were captured in this research project so there was no possibility of linking the information collected. Participants

were assigned a unique study number (e.g., Participant 1 (P1), Participant 2 (P2) etc.) during the collection and analysis of the data. This number was used on any research-related information collected about the participants during the course of this study to ensure participant anonymity was protected and kept confidential. Furthermore, the researcher is the only individual with this information, and the list that matches the participants' names to the unique study numbers that were used on the participants' research-related information will not be removed or released without their consent unless required by law. All written notes (e.g., journal, demographic surveys, and transcripts) were kept in a locked filing cabinet and electronic files stored in a password protected computer file. Following the completion of the study, all written notes will be kept in a locked filing cabinet and electronic files stored in a password protected computer file for five years, after which they will be destroyed.

The audio recordings of each interview were transcribed verbatim. Names of participants were not used during the audio recorded interview, but any personal identifiers that were inadvertently included in the recordings were removed from the written transcript. Electronic files were password protected and/or saved on encrypted computers for safe mobile storage. A transcriptionist service was used, and the confidentiality expectation and aspect of this study were reviewed and a confidentiality form signed. Audio files were sent, using standard online file transfer systems. Anonymity of the participants was protected with institutional names and identifying information removed during the transcription. If a participant was accidentally identified during the interview, the identifying information was eliminated from any written transcript.

Chapter Summary

In this chapter, the rationale behind the chosen interpretive description approach to inquiry has been described and located within the appropriate paradigm of scientific inquiry. An overview of the study's research methodology was discussed and the methodological underpinning upon which the study was designed outlined. Theoretical and personal assumptions shaping the design platform of this study were identified and detailed design and analytic processes were highlighted. Furthermore, this chapter outlined multiple principles that guided evaluation and credibility of this ID study and its specific ethical considerations. In the next chapter descriptive results generated through analysis will be provided.

Chapter IV: Findings

Introduction to the Findings

This study explored nurse leaders' experiences of moral distress within the Canadian health care system. Three essential research questions have guided this study.

1. How do health care nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian health care system?
2. What institutional, professional, and personal approaches and resources do nurse leaders recommend to address moral distress and how does the interpretation of those recommendations help us understand the situation of nurse leaders?
3. What are the implications for nurse leaders' real-world practices that promote the development of a positive quality of personal and professional life for leaders and what are the policy implications for institutional healthcare environments to diminish conditions that produce moral distress?

Thirty-two nursing leaders, mainly managers and directors, were interviewed between May and September 2015. These leaders shared their experiences of moral distress as nursing leaders and how it impacted their lives personally and professionally. The interview prompt questions were designed to explore the feeling of moral distress as it manifests within nurse leaders, their understanding of that experience, implications of moral distress on leaders' decision-making and their relationships with colleagues and family, and strategies for coping and emerging from the psychological, social, and professional impact of moral distress. Three major thematic groupings or patterns of ideas emerged during the course of data analysis, each addressing the study's essential research questions. These groupings were as follows: leaders

suffer moral distress and are not simply protagonists in causing moral distress in their followers; relationships matter, both in the midst of coping and emerging from moral distress; and navigation through moral distress requires institutional, professional, and personal strategies. As these thematic patterns evolved, I came to understand an overarching metaphor, an ethical whirlwind that effectively describes the experience of moral distress in nursing leaders.

Before exploring the findings, this chapter begins with a summary of interviewee demographics so the reader can situate the thematic patterns and overarching metaphor within the participant context.

The participants. The convenience and purposeful sampling began by sending 25 emails to colleagues within the health authority in which I worked in British Columbia to request a research interview. This email request was sent on a late Friday afternoon when I promptly received six immediate positive responses. Within two days another 11 affirmative responses were obtained. Additional participants were obtained through three additional email requests to colleagues that worked within British Columbia but outside of my health authority; all agreed to participate. Thirty further interview requests were distributed, resulting in 13 additional participants. The distribution of provincial responses was as follows: Alberta (n = 2); Saskatchewan (n = 2); Manitoba (n = 1); Ontario (n = 3); Quebec (n = 1); Prince Edward Island (n = 1); New Brunswick (n = 1); Nova Scotia (n = 2) (Figure 1). In summary, 60% of participants (n = 19) were sampled from the province of British Columbia.

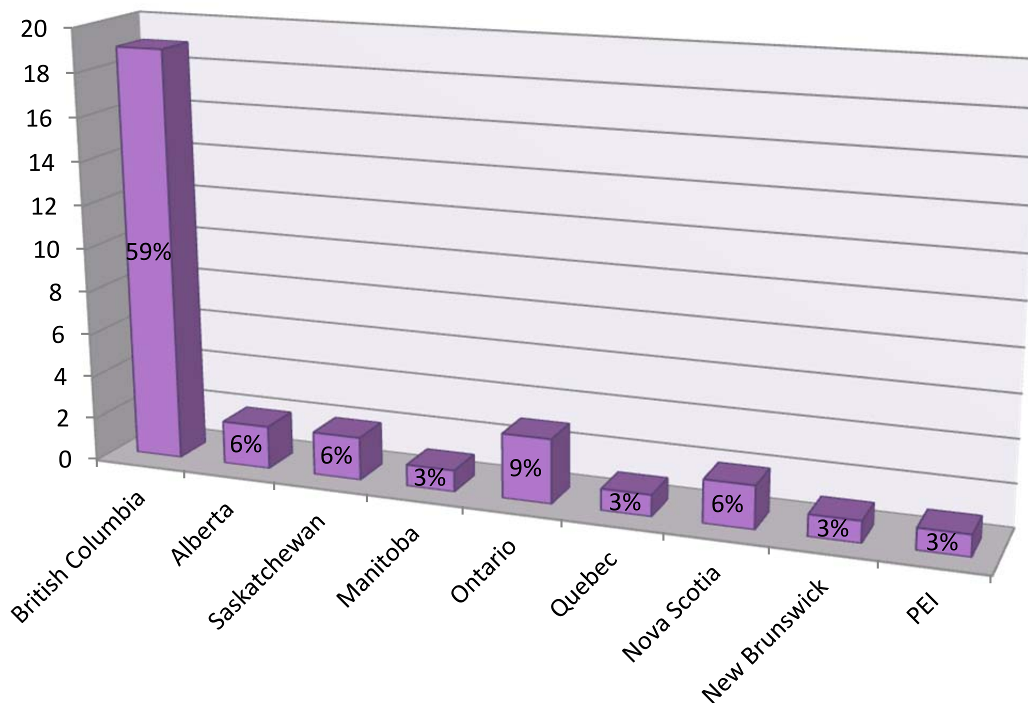

Figure 4.1. Provincial distributions of study participants.

Table 4.1 summarizes the frequency distribution of study participants as well as the geographical location (province) of the 32 participants. Additionally, 30 participants were female and two were male. The sample of participants between ages 51 and 60 (n = 16) was the largest group interviewed with the next highest age grouping being 41–50 (n = 10).

Table 4.1.

Frequency Distribution of Study Participants

Frequency Distribution of Study Participants			
Variable	**Category**	**Frequency (n = 32)**	**Percentage (%)**
Province	British Columbia	19	60
	Alberta	2	6
	Saskatchewan	2	6
	Manitoba	1	3
	Ontario	3	10
	Quebec	1	3
	Prince Edward Island	1	3
	Nova Scotia	2	6
	New Brunswick	1	3
Age	20-30 years	0	0
	31-40 years	2	6
	41-50 years	10	31
	51-60 years	16	50
	61-70 years	4	13
Gender	Male	2	6
	Female	30	94

Participant leadership roles included managers (n = 20), directors (n = 9), executive directors (n = 2), and senior operating officers (n = 1). Years of experience as a registered nurse ranged from 10–47 years. Years of experience as a nursing leader ranged from 5–30 years with a larger variability observed in the years of experience in their current role, ranging from one month to 25 years (Figure 4.2). Note: in one health authority where several participants were or had assumed new roles either at managerial, director, or executive director levels, reorganization

was in progress. Only one participant was new to an organization (eight months) while all others had been with their organizations for many years.

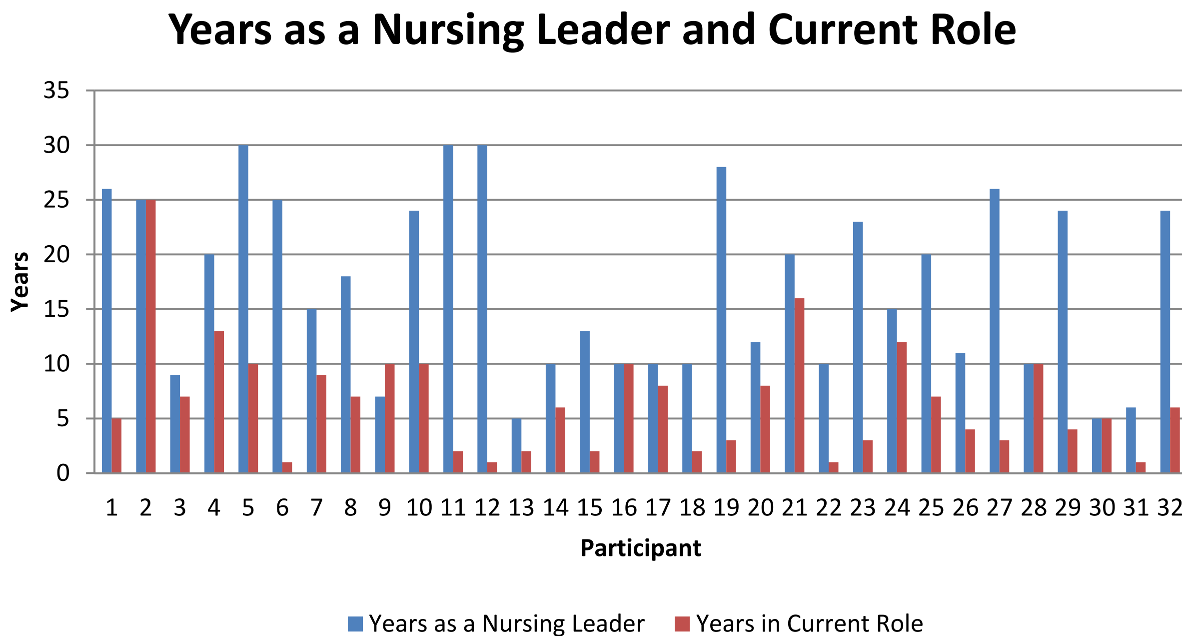

Figure 4.2. Years as a nursing leader and current role.

The participants represented a wide range of formal educational levels: one was diploma prepared, 13 baccalaureate prepared, 15 master's prepared (14 in nursing and one in business administration), and three doctoral prepared. Two participants also had additional academic degrees including a nurse practitioner and masters in health care and quality.

Before assuming a formal leadership role, all participants had previous experience in one or several of the following front-line nursing leadership roles: charge nurse, patient care coordinator, clinical nurse educator, or site supervisor. One nursing leader worked as a nurse practitioner for eight years before returning to nursing administration. Two participants who worked as senior nurse leaders had previous experience as interim vice presidents of nursing or chief nursing officers. Two participants were prominent nursing leaders in academia.

The participants of this study represented 12 health authorities across Canada and one academic facility. Participants represented various multiple acute care areas including the following: emergency /trauma services, rehabilitation/allied services, critical care/ICU, medicine, maternity, mental health, cardiovascular services, access & patient flow, palliative, surgical and inpatient services, ambulatory care, residential, and site operations (all acute hospital services). Twenty-two participants worked in urban settings, eight in rural settings, and two in both urban and rural settings. Almost all of the participants reported working more than the allocated hours of the role with the number of hours worked per week ranging from 36–80 with an average of 51 hours (Figure 4.3). Overall, 88% of participants reported working greater than 40 hours per week.

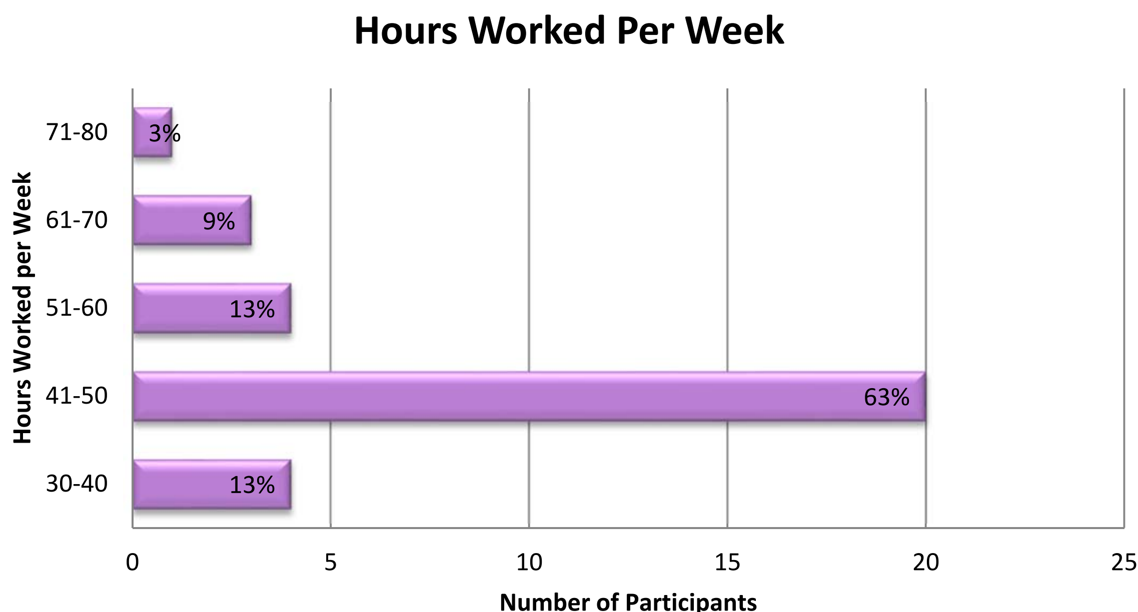

Figure 4.3. Hours worked per week.

The span of control, defined as the number of people directly supervised by a manager or leader, varied as well for participants ranging from 25–2000+ employees (Figure 4.4). The majority of study participants (41%) had a span of control between 200 and 2000 + employees.

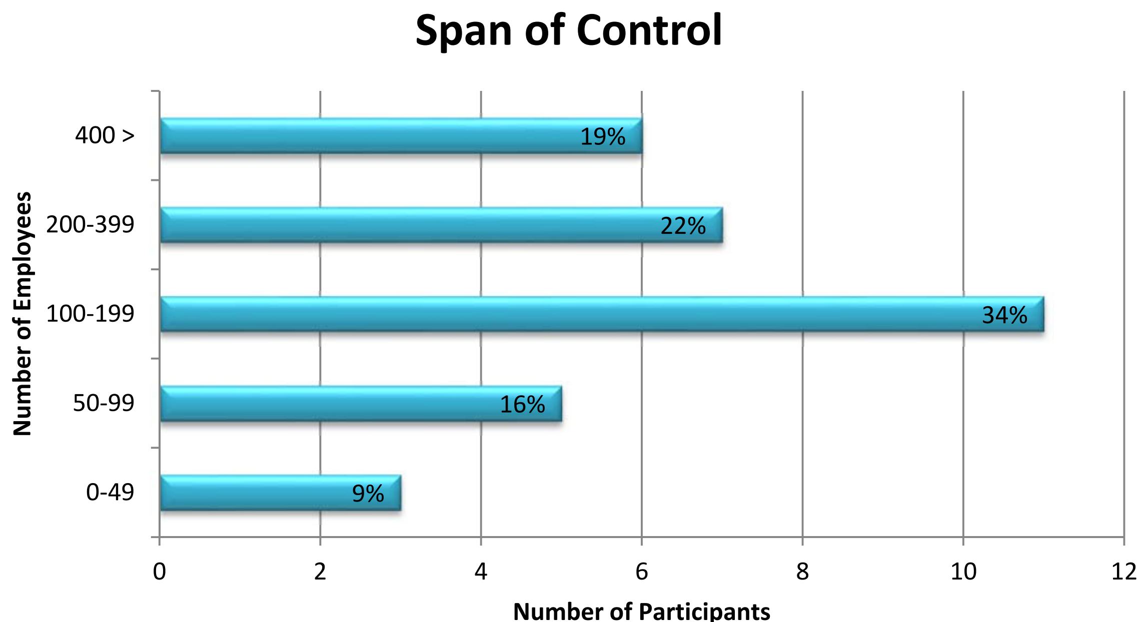

Figure 4.4. Span of control.

The interviews. Individual in-depth interviews (n = 32) were conducted between May and September 2015. Each interview was scheduled for a day and time convenient for the participant with each interview being held on a separate day. One to two interviews were scheduled per week over the course of approximately 18 weeks. There were 14 face-to-face interviews and 18 telephone interviews. All but four interviews took place during a normal working day so the duration of the interview was an important consideration. The duration of each interview averaged approximately 60–90 minutes. All interviews followed the protocol outlined in Chapter III.

While I anticipated interview material to have depth and detail, I did not foresee how rich or vivid the disclosures would be. The interviews were often deep, full of experiences that articulated the context and history of the situation in fine detail that surpassed superficial answers. The depth and disclosure allowed for examining layers of meaning, gradually unpeeling the proverbial onion to get at the heart of the matter regarding those ethical situations

that created or were perceived to create moral distress and memories of suffering and turmoil for nursing leaders. The intense and intimate narratives reinforced the level of trust, vulnerability, and confidentiality that participants afforded me. The conversations were fluid and robust with participants who had a current or prior professional relationship with me. The fluidity and information sharing was also facilitated by virtue of my professional experience as a nursing leader similar to the participants. As Thorne (2008) noted, “there may be various advantages associated with having insider privilege, including more straightforward access to information, consultation, and background contextual information” (p.118). Saturation of themes and experiences was reached with the 32 participants. Throughout this chapter, a labeling system of P1 (Participant 1) through P32 was used to identify participants to protect their identities and to document the inclusion of all interviews in the analysis.

Structure of the findings. The findings of this study are organized with moral distress as an ethical whirlwind, the overarching metaphor, presented first followed by three thematic groupings or patterns of ideas that emerged as I gained an understanding of the experience of moral distress in nursing leaders.

The metaphor that emerged from this study evolved from data collection gathered from interviews and the analysis, each informing the other in an iterative process. Throughout data collection, participants were asked to reflect on the following three questions:

1. Tell me what it is like working as a nursing leader within the Canadian health care system.
2. Have you experienced moral distress in your current or previous role and if so describe the situation?

3. How widespread do you think moral distress within the nursing leadership role is in the current health care environment?

The broad nature of these questions elicited poignant and compelling descriptions of the participants' accounts of ethical situations that had created moral distress for them, as well as revealing their perspectives about moral distress within Canadian health care and the nursing leadership role. As I analyzed the interviews, I asked myself: "What ideas are starting to form? What are the data telling me? What am I missing? What is it I want to know and is there a relationship between that and what the data are telling me? This analytical process exposed ideas and patterns of meaning that provided a more integrative understanding of the experience of moral distress.

Three major thematic patterns emerged through this process. The first was that leaders suffer moral distress, too. While often viewed in the literature as the cause of moral distress for employees, one of the powerful observations that emerged from the interviews was the presence of moral distress within leaders. In short, leaders suffer, too, and they suffer in similar and different ways from their employees. The second pattern was the importance and pivotal role of relationships for nursing leaders, during the experience as well as in navigating and emerging from moral distress. The final thematic pattern involved how participants used their experience and the elements within that experience to create common coping strategies and recommendations that involved the individual leader, his/her relationships, and implications for the organizational environment.

These three thematic patterns were important structural components in building the overarching metaphor that helped me understand the nature of the experience of moral distress in nursing leaders and allowed for a further understanding of the phenomenon from a leadership

lens. After discussing the ethical whirlwind, the thematic patterns will be explored to gain insight into understanding the experience of moral distress as an ethical whirlwind.

Moral Distress as an Ethical Whirlwind

Moral distress is the stress experienced when a health care provider knows the right ethical course of action to take but is constrained from taking this action. Throughout data collection, instead of focusing on describing the right ethical action or constraint, participants described common elements that captured their entire experience of moral distress. Specifically, they shared what the experience of moral distress felt like, how it physically, emotionally, and cognitively impacted their lives, and what the experience meant for them as leaders and nursing professionals.

Moral distress was a confusing and tumultuous experience that encompassed more than constraint in action and conflict in ethical values. Instead, participants consistently described how the experience was full of intense energy with multiple variables involved in the experience. These variables were often interpreted by participants as the ever changing influences within the dynamic environment of health care. Advancements in technology, increased longevity, health care operational resources, a corporate ethos, and changing societal values (e.g., advancements in medical practice, complex co-morbidities, end-of- life decisions, and acute and residential care capacity) added to the complexity in the delivery of health care and expertise required of leaders to navigate new ethical situations created from these variables. With nursing leaders straddling the clinical and administrative domains of health care, participants expressed increasing moral angst and distress due to advancements in these biomedical and corporate influences that constrain enactment of moral agency. Overall, participants expressed a belief that moral distress was always present among nurses and nursing leaders somewhere within the health care

organization due to the complexity of the nature of the work of helping others. Their descriptions centered on how health care providers and leaders must not only consider what is best for the patient in the present and future, but also the accompanying socioeconomics variables associated with those decisions which were perceived to be complex in nature.

Participants shared that moral distress is a personal and subjective experience where proximity to the patient, operational responsibility, organizational financial performance, the level of engagement and support of senior leaders, larger socio-political power dynamics, and previous experience determined if the ethical situation created moral distress for a nursing leader. Regardless of the trigger, the interpretation common to all participants was that the experience was a deeply personal felt experience impacting the individual on many levels: personally, professionally, and relationally. All interviews evoked an all-consuming and embodied experience that affected an individual's entire being—emotionally, physically, and mentally. What follows is a description of this embodied experience according to the participants' interpretation of their experience of moral distress.

The emotion of moral distress. When participants were asked how they recognized they were experiencing moral distress, all participants described an emotion they distinctly experienced or a feeling of something "being very, very wrong" (P3). In this study, only negative emotions, feelings, and physical symptoms were initially used to describe experiences of moral distress. The predominant negative feelings participants associated with moral distress were anxiety, anger, and frustration. For example, one participant reflected on the anxiety she experienced during a high-profile initiative she was leading:

> I literally felt like it was going to kill me. I was having panic attacks, palpitations, tachycardia…it was just so heavy. Also, I was sleeping with my fists balled up under my chin, jaw clenched, in a fetal position, that's how my anxiety manifested. I got a

> prescription for Ativan at one point. I've never taken Ativan in my life and still haven't, but just to have the prescription made me feel better. (P17)

Another shared how her anxiety felt in her role and the humor she and her colleagues attached to this emotion:

> It's actually funny but not funny. I've always said I feel like I've got this rat running in my gut, it was constant anxiety and worry. So at Christmas time, my boss gave me a toy hamster running on a wheel. I could turn it on at my desk every time I felt anxious and just laughed, so it released a bit of stress. (P18)

Multiple individuals shared that situations triggering moral distress significantly impacted them emotionally, triggering many sleepless nights and severe anxiety or sadness. Their descriptive comments included "I felt torn; I couldn't turn my brain off; It was all consuming; What will be the outcome if I don't; I kept questioning myself; and I was sad that. . . . " Many bravely shared how socio-political power dynamics and corporate fiscal constraints caused their severe anxiety and sadness that manifested into clinical depression for which they sought medical attention. As one shared, "It has landed on me in a very deep way in a sense that there have been changes in my mental health dealing with what has been a higher level of consistent and ongoing stress" (P15). Another shared the moral distress associated with being pressured by senior executives to hire "a friend" of the supervisors. The participant was clear in her values about hiring the right and appropriate person; however, the politics and pressure became so intense the participant had to take time off work:

> I was overruled on that hire. That's the kind of stuff that for me is like what am I doing here? It's this internal fight to understand is it me that's really not a good leader here? Is it me not understanding something, really blaming myself or just attaching the turmoil to my not understanding and to my perhaps not being competent? I was probably the lowest I've ever been [after that event]. It affected me emotionally. I had a lot of sleepless nights, severe anxiety I was diagnosed with depression so I took some time off. It was the worst year of my life but I had to do it because I knew that if I didn't get back to work and kind of start to contribute, I probably would go down even more. I mean as a nurse I was now a patient. I felt hugely vulnerable for a year that I had never felt before in my

> life. I had to finally reach out; as a nurse I was reaching out for help professionally and personally. (P19)

When asked what this experience meant for this participant as a leader, the following response was garnered:

> I hit rock bottom and started to blame everything on myself. It took a while, but I realized that it's not all about you. I started to get stronger and more confident, and it was like fuck this is not about me, this has nothing to do with the way I was thinking or feeling or whatever, it was really about the position I was put in that created a lot of dissidence. In the end, I had to leave my dream job because of unethical politics. (P19)

In the example above, the ethically distressing elements that challenged the participant were power dynamics and the pressures to conform to unethical and inappropriate action of hiring the wrong candidate. For this participant, this experience had a significant negative impact on her personal health and well-being as well as her professional career.

Anger and frustration were the other two predominant negative emotions expressed by interviewees. These emotions were perceived to be related to system constraints they encountered within their organization and the professional responsibility they held. On a more granular level, the anger and frustration was grounded in a sense of abandonment by the organization and support of executive leadership support. As an example one leader shared the following:

> You just feel so responsible and then it turns into anger. You get mad because nobody is doing anything or willing to do anything. . . . I guess I've realized what it is I can do and what I can influence and I will do those things. If I can't get any farther than that, it is what it is. It's taken many years to learn this. (P17)

Many shared the self-doubt and guilt they felt during an experience of moral distress. Whether it was expressed as struggling with a decision made that impacted personal and professional values, manipulating systems to meet patient needs, not being transparent, or failing to advocate for patient care, these feelings were associated with an awareness that actions had

impacted or injured someone else. Their thoughts centered on the unique complexity of some situations, whether they were doing the right thing, and the resulting implications of their decisions. One participant further reflected on how these emotions linked with shame that arises from doing something improper.

> I think there is some guilt associated with moral distress; maybe there is a sort of that shame blame. We don't have the skill set we need or maybe we think we could be implicated by it, so best not to deal with it. (P5)

Most of the examples that were shared by participants were recent or had occurred years prior with a significant sentinel event associated with the experience. Regardless of when the event occurred, the intensity of the emotion varied in participants. As a researcher, I could feel the intensity of the participants' emotions associated with the event through the descriptive words chosen by the participants: "It's going to kill me"; "I'll never allow myself to be that vulnerable again"; and "It was a horrible experience that still causes a sick feeling in the pit of my stomach," to describe the intensity of the experience. In one moving description of how the experience felt for one participant, strong imagery was conveyed that illustrated the emotional and physical experience.

> It was a personal attack. It was very distressing. It was over a clinical situation that I felt was extremely unsafe and one of the most upsetting circumstances that I have been involved in regarding communication with another professional. I think physically it felt like I had been punched in the gut for about two weeks and it took me a while to get my feet back under me again and figure out how to deal with it. (P22)

When moral distress compromises personal or professional integrity, *moral residue* occurs. Webster and Baylis (2000) defined moral residue as "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 218). One of the surprising findings of this study was the level of emotion the participants conveyed during their reflection

of their experiences (often from months or years ago) with moral distress. While 30 of 32 of the participants confirmed that they had experienced moral distress within their roles, nine individuals had significant emotional reactions or moral residue while sharing and reflecting on their experiences. This was observed during the interviews either audibly (e.g., changing pace, rhythm, tone of their voice, crying, or silence) or physically (e.g., flushing, physical restlessness, or trembling). In one instance, the interviewee physically started punching the air and became very flushed during the telling of the story. When this observation was reflected back to the participant, she shared the lingering emotions and physiological response that remained,

> It's like I can feel that churning inside of me after all these years, I can still feel that guilt a bit in that I compromised some of my beliefs and my faith so some questioning in myself. I guess the feelings inside were so mixed and intense then and those feelings are still there. (P2)

Four interviews were halted due to intense emotions, such as crying or the participant requesting a break, triggered from sharing the experience. The workplace situations that triggered these emotions involved lack of supervisory support, insufficient delivery of safe patient care, and the extreme pressure to conform to initiatives that compromised personal or professional values. At the end of the interview, none of the leaders reported feeling distressed. The intensity of the emotions displayed from past experiences clearly revealed the importance of the need for leader support as individuals continued to manage and lead through difficult ethical situations. Many of the participants expressed a sense of relief and closure from talking about their experiences of moral distress during the interview. A further unanticipated finding was the impact of the emotion attached to the experiences shared in the transcriptionist involved in this study. At the midpoint of the transcription process, the transcriptionist even shared how "heavy and painful some of the stories were to hear." From indirectly engaging with the poignant and compelling experiences of participants through transcription, an indirect source of secondary

traumatic stress was observed. Support and debriefing were given to the transcriptionist once this was disclosed.

An unexpected finding revealed by several of the participants was the importance of controlling one's emotions as a leader and in harnessing one's non-verbal body language. Several participants discussed the relevance and tension of showing emotion within the organization. For example, when asked about senior leaders and emotions and moral distress, one participant stated that there was an underlying expectation to remove emotion. The participant stated, "I think it frankly depends on who is at the helm. If you have someone at the top who is not a people leader and not able to relate or has a lower degree of emotional intelligence, it will trickle down. Our organization speaks of respectful workplaces and of being creative and expressing your emotions and talking to your leaders and all this kind of stuff but we don't act it well at the senior leader level at all" (P 18). Another participant shared how she utilized an executive coach to observe her in chairing meetings to "watch my style, my tone, my communication technique, because I wanted to make sure I wasn't reacting, to figure out what my triggers are and be aware of them" (P26). Thus, there is an undercurrent within the leadership culture to be self-aware of one's emotions and in controlling them as one moves up the leadership ladder.

The physical impact of moral distress. Each participant was asked to reflect on the impact of moral distress on his or her physical well-being. Physical reactions that were reported included gastro-intestinal upset (nausea/diarrhea), weakened immune systems predisposing participants to colds or influenza, tachycardia, palpitations, angina, high blood pressure, headaches, muscle tension, weight loss/gain, insomnia and exhaustion. While all of these symptoms were frequently noted, one of the most prominent was insomnia and exhaustion with

participants reporting they had difficulty falling asleep or waking up during the night and unable to fall back to sleep. “The physical impact is it makes it hard to sleep. Your brain doesn’t stop. Your heart rate gets faster. You have a heightened anxiety about what’s next and what else can I do to prevent it” (P14).

While a variety of health conditions were identified, there was an inherent understanding of a potential for serious long-term effects on health such as cardiovascular disease. In addition, several participants commented on a link between engaging in unhealthy behaviours and moral distress. One participant stated the following:

> I see and hear of senior leaders engaging in really unhealthy behavior and I wonder sometimes is that because of moral distress. Everything I’ve heard from over-eating, lack of exercising, and lack of caring for themselves. Some folks talk about drinking a lot on the weekend, and a common thing I’ll hear is “Let’s go have a drink,” which isn’t good for your health. Sometimes I think that we, who are supposed to be so well educated, don’t know how to manage moral distress in a way that’s constructive to our own well-being (P5).

Finally, regardless of the physical symptoms of illness, the majority of participants noted that they did not take sick days. The reason shared, “The work keeps accumulating,” “I have to be extremely ill” or “be on my death bed.” Here, the participants felt the need (from the workload) and expectation of organizational responsibility to remain available regardless of physical symptoms and illness leaving them vulnerable to further sequelae.

The meaning of moral distress. When asked what the experience meant for them as leaders and nursing professionals, a variety of interpretations were acknowledged. First, participants shared how “profound” their experiences were for them. When asked to elaborate on the profound nature of the experience, participants immediately began discussing their value system and reflected on the morally difficult elements that they struggled with as a leader and nurse in their experience of moral distress. Here, the participants were clear in their disclosure of

how deeply connected they were to their ethical framework. While participants acknowledged how ethically difficult situations challenged their ethical framework and values, these also gave them a sense of direction and stability as they navigated through the situation.

Another element contributing to the profound experience was the recognition by participants of the far-reaching impact of moral distress that some situations created. The participants shared the importance of "stick-handling" or controlling the situation to mitigate further rapid spread within an organization or community from a micro to meso or macro level. While the participants felt the need to be in control, many shared how leaders must recognize that it is impossible to control all elements involved in a situation that creates moral distress: one must learn how to live and cope through these situations so that it does not have a lasting personal impact. Moreover, some participants expressed the immediate attention required of leaders during ethically difficult situations to mitigate further negative impact on patient care, organizational ethical climate (e.g., low morale and attrition), and public image of the organization and health care.

While participants predominantly acknowledged the emotional and physical response to moral distress in a negative context, many shared how moral distress created personal transformation and self-growth after the experience resolved. Participants described increased self-awareness (in how they responded to stress), added confidence, increased patience and less reactivity, enhanced understanding of the value of resources and collaboration, and acquisition of new knowledge. In addition, one participant shared that her risk tolerance as a leader had increased from her experiences of moral distress. She stated, "morally distressing situations have pushed me into making very difficult decisions," which she viewed as positive and an added leadership competency (P1). Other positive outcomes of moral distress that participants

identified were an acknowledgment of the value of the work in the nursing leader role and the importance of remaining present in the moment, staying grounded, mindful, and open to learning.

Many of the participants also described the relevance of length of service and experience as a nursing leader related to their ability to navigate and cope with morally distressing situations. Previous experience with ethically difficult situations and moral distress in the clinical and administrative environment provided a moral compass for direction and knowledge. For example, one leader reflected on how she has grown as a leader in managing staff performance issues like narcotic theft. The first time navigating this situation as a leader was difficult, “but after a few over the years, I know what needs to be done” (P4). Another shared the following:

> It’s kind of interesting because I now feel quite qualified in dealing with significant ethical situations because I’ve heard it all and I’ve seen it all. As an Emergency nursing leader, I’ve heard every kind of thing that can happen in a person’s life. I don’t know if every manager has this experience. Employees have suicides in their lives, they’ve had assaults, they’ve had home invasions, and they’ve had people in their families literally getting murdered. All of it is brought to work with the individual impacting patient care and the unit. I have heard it all so I don’t think anything surprises me. . . . If you don’t balance out, then the role will drag you down. I still have to watch myself. (P17)

Experience played a significant role in the meaning making process of moral distress for nursing leaders. Learning through reflection of doing was shared consistently across all participants as a key factor in building coping strategies for future experiences. As one participant stated, “No one can tell you or teach you the right course of action to take. In some situations, you just have to figure it out on your own. There is no recipe, but you remember the ingredients the next time you are faced with a similar situation” (P11). While the organizational environment or structure provides developmental experiences, it is how these experiences shape memory and coping behavior when confronted with a future similar situation that was noteworthy.

Ultimately, participants acknowledged an inherent understanding of the negative impact moral distress could have on individuals and that its impact can extend beyond the walls of health care institutions. With the pressure to perform as a leader palpable within these participants, many expressed the significant need for organizations to critically look at this phenomenon due to the complexity of situations and current stigma present of letting others see one's struggles, including those of moral distress.

The ethical whirlwind. The overall feeling and experience of moral distress echoed by several participants was the presence of a dynamic non-linear continuous interaction between the organization (external) and the nursing leader (internal). This interaction between the structure and agent is constantly changing. As the above comments revealed, periods of moral distress were times of considerable emotional, physical, and cognitive turmoil and suffering for most. Many talked about how ethical situations are inevitable in nursing practice where the clinical context of extenuating variables and urgency escalates within a highly complex shifting health care system. The experience of moral distress was not a passive experience. Instead, it was described as a period full of "intense swirling energy and motion" (P20) or a "spiraling action" (P10) with constantly changing dynamics influencing the situation. Several participants described the experience as a "whirlwind" of events colliding through intersections of ethics/values, clinical practice and the patient situation, politics, and relationships (patient, families, staff, and society) (Figure 4.5).

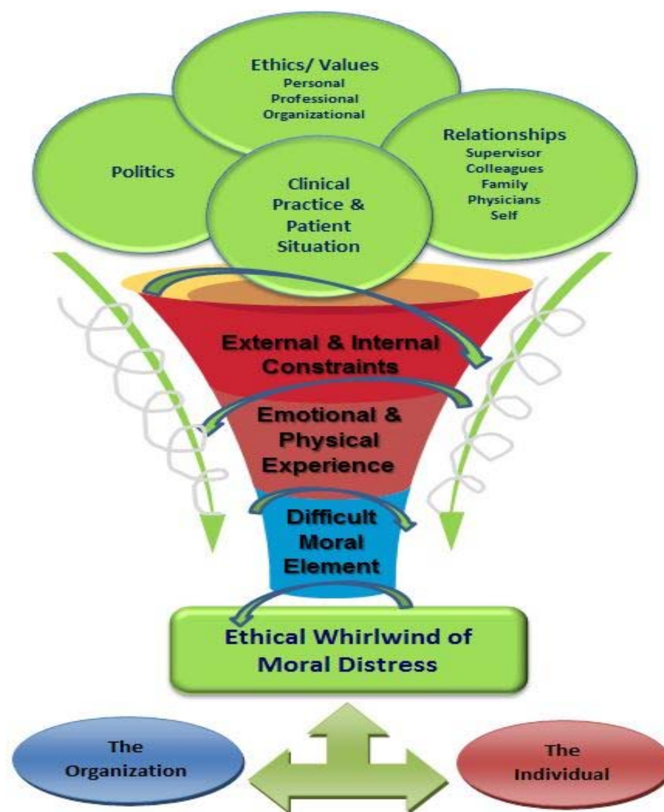

Figure 4.5. The ethical whirlwind of moral distress.

Contributing to the tensions already colliding, external and internal constraints, individual emotional and physical reactions, and the morally difficult elements igniting the moral distress were also identified as contributing to the experience of a whirlwind. While constraints that prevent nurses from enacting their moral agency within their practice environment have been well identified in the literature (Huffman & Rittenmeyer, 2012; Storch et al., 2002; Varcoe et al., 2004), the ethical dimensions of the workplace have not been included. In this study, nursing leaders were asked to identify root causes or moral elements/dimensions that created moral tension for them as a nurse and leader. Table 4.2 captures the predominant morally difficult elements/dimensions experienced by these participants. See Table 4.3 for additional elements/dimensions identified.

Table 4.2.

Difficult Moral Elements/Dimensions in Moral Distress Experiences of Nursing Leaders

- **Advocating for needed resources professionally versus organizational fiscal constraints required as a leader**
- **Adverse patient events**
- **Manipulating systems or telling white lies to secure resources for patient care**
- **Inappropriate leadership action impacting patient care (i.e. nepotism in hiring practices of senior leaders]**
    - **self-serving nature of leadership**
    - **manipulation of others**
- **Transparency and alignment of personal, professional, and organizational values**
- **Inappropriate actions of physicians regarding financial gain versus patient care**
- **Maintaining confidentiality, professionally and organizationally, when inappropriate accusations are made by society about patient care or staff.**
- **Disparity between professionals regarding patient safety values**

Overall, leaders experience a sense of confusion, turbulence, and instabilities during moral distress. The metaphor of an ethical whirlwind can best describe this moral distress experience. The confusion and navigation in this constantly changing ethical swirl is compounded by the interactions of the elements/dimensions involved in the whirlwind. For example, one participant reflected on how advancements in technology have recently added to situations that create moral distress and the experience itself:

> I think as the years have passed, it's harder to navigate ethical situations. There are more avenues in which stories can swirl through things like texting and all that underground communication that happens that you really don't have any control over. There's lots of chatter especially during those times of great stress when these swirls add and compound the distress. (P27)

There is a dynamic interplay between the structure and agent with this ethical whirlwind occurring both externally but internally as well. Participants expressed the isolating feelings of navigating ethically charged situations alone. A sense of intimacy emerged as participants

described the situation as "touching me at my very core" (P26) or "impacted the soul of my being" (P3).

Finally, the ability of leaders to recognize moral distress varies. Some stated that they were able to recognize the experience right away. Others experienced a more delayed response. For those who recognized it immediately, there was a general understanding that they didn't "want to be here" and "how did I get into this?" For others, it took weeks, months or even as long as a year to recognize they were experiencing moral distress. "At first I thought it was a disagreement," said one. "Once it started hurting other people, and it started creating rifts between other front-line colleagues, lots of gossip, lots of negativity, I then saw it was morally distressing" (P3). Others noted that they realized they were experiencing moral distress when they became aware of the emotions when they felt "something was eating away at me" (P18) or when they started "verbalizing the morally difficult elements with staff, colleagues and family" (P24). While there were a variety of responses as to when moral distress occurs, for participants in this study, it could occur in response to one event or could be the result of multiple competing demands or concurrent situations that challenged their value system as a nursing leader. There was also a variety of interpretations of how frequently moral distress could occur ranging from daily (depending on the position and role one was in) to several times a year. As for duration, there was variation, but all agreed that moral distress could last long periods of time. For example, one participant shared that the situation creating the moral distress for her "lasted two and a half months but it still lingers on because I haven't fixed the relationship with that other manager" (P3). In many ways the recognition, frequency, and duration of moral distress highlight a link to the importance of relationship with self and others as it pertains to moral distress, which will be discussed later in this dissertation.

Summary of moral distress as an ethical whirlwind. It is clear from the emphasis of participants' accounts that moral distress is more than an "it" that one has or does not have. For nursing leaders, moral distress is a deeply personal and subjective experience that is contextualized as a period full of intense energy and motion occurring both within and between the individual (internally) and the organization (externally). These systems interact with one another as a swirling ethical whirlwind in which values among the individual moral agent (nursing leader), organizational environment and society are in constant dynamic non-linear interaction and tension. Additionally, moral distress was understood to be an all-consuming and embodied experience, drawing individuals into a vortex affecting their emotion, body, and mind.

In this study, only negative emotions, feelings, and physical symptoms were initially expressed to describe participants' experiences of moral distress. These reported emotional and physical symptoms were quite significant such as insomnia, exhaustion, and changes in mental health that affected the participants' overall health and, for some, their professional careers. It seems noteworthy that, despite understanding the potential risk of harm to themselves when physical symptoms occurred, many participants nevertheless engaged in continuing to work when physically ill due to a felt need (e.g., workload) and expectation of the organization. The morally difficult elements of the ethical situations experienced by nursing leaders were identified, as well as the areas of self-growth that the experience afforded the leader were shared.

Through participant narratives, the importance of individual ethical frameworks was illuminated as a tool to help leaders navigate morally distressing situations. Furthermore, learning from the experience played a significant role in the meaning-making process of moral distress for nursing leaders and also played a key role in building coping strategies for future situations. To help the reader further understand this ethical whirlwind experienced by nursing

leaders, the three thematic patterns revealed in the data collection and analysis will now be discussed.

Leaders Suffer, Too

Responses to the three main prompt questions within each interview elicited a tidal wave of stories of moral distress. Participants would begin their response to questions by describing their experience as a nursing leader in Canada with specific adjectives including "challenging, exciting, interesting, frustrating, dynamic, never-ending, opportunity, political, isolating, complex and overwhelming." After sharing these descriptors, the participants would often reflect on their commitment and dedication to this nursing role, which was strong and deep. Participants expressed a passion and love for their work when they could actively make a difference in patient care, influence and create health care policy and change, support staff through change, provide mentorship to new nurses and leaders, engage in creativity and innovation, and facilitate growth of the nursing profession across the country. The sense of accountability and responsibility within their role was captured by one participant who stated:

> It's a mixture of pride, panic and overwhelming responsibilities. I always felt an incredible amount of pride in the role and the opportunity to bring on new staff, work with the patients, work with the staff, and generate that sense of pride in creating a great work environment. I was always very proud to say I am a nurse manager. Panic because in this role there is a huge sense of responsibility and this is probably something that I struggled with for my entire career as a nurse leader. Fear that something was going to go wrong because when things did go wrong the responsibility regardless of the hour when it happened it was the nurse leader's responsibility. There was always that kind of underlying responsibility; is everybody showing up today, are the right people coming to work, are they coming with the right heads on and that kind of stuff, so panic and what comes with that is the responsibility. It's huge the responsibility and it's not implied responsibility. Everything is fine until something goes wrong. (P20)

Participants were also very clear in acknowledging how they wrestled with a multitude of ethical tensions of varying intensities on a micro-(patient), meso-(organizational) and macro-(community/provincial/national) level. It was precisely these myriad of varied ethical

tensions paired with the nurse leaders' commitment/ accountability/responsibility (organizationally and professionally) and advocating for the best interest of individuals (patients/families, employee, organization, and community) that participants believed contributed to or created their feelings of moral distress. In addition, many of the participants shared they inherently understood the experiential situations and clinical patient situations that front-line nurses experienced as they had professionally "walked in the same shoes" (P24). As one participant stated, "I recall many nights when I was a front-line nurse sitting in the car after shift just crying, feeling so emotional because something had happened that shouldn't have happened" (P4). Furthermore, several expressed they felt more aware of moral distress in the clinical environment (within the department and among employees) than their allied colleague leaders due to their professional "way of knowing." Thus, nursing leaders' attempts to make sense of and recognize moral distress within the clinical environment implied an association of moral distress with previous personal clinical experiences as a front-line nurse.

After describing the broader experience of the responsibilities of being a nursing leader, the participants openly shared their poignant and compelling stories of moral distress. Participants used a variety of examples drawn from everyday work to 188adverse patient events to locate the sources of their moral distress. All but two participants readily acknowledged they had experienced or were experiencing moral distress within their roles. For those who could not initially identify current examples, further probing questions of past nursing leadership experiences revealed previous experiences of moral distress as a leader.

The ubiquity of moral distress. What is vividly apparent from the interviews was the overwhelming affirmation and recognition that nursing leaders do experience moral distress and that it is ubiquitous within the nursing leadership role. The importance of having an opportunity

to be heard in relation to their experience was one of their reasons for agreeing to participate in this study. Several participants spoke of the timeliness of the study due to reorganization (in two health authorities) and its impact on employees and the organization, the perceived paradigm shift in health care to a more business-centric model of care, and the expectation of others (organization, professional body, and employees) in resolving ethical conflict. The majority of participants expressed a desire to communicate to a larger audience that nursing leaders experience moral distress from patient-centered situations as well as from constraints imposed by organizational and government directives requiring difficult ethical decisions. Participants were clear in their assertion that nursing leaders are not immune to the emotional turmoil created by these constraints and the implications of the decisions made to navigate through the complexity of ethical situations. One participant expressed an overwhelming "need to communicate" the weight of moral distress and its extension into nursing leadership, stating,

> I would say every single manager in health care I have seen has suffered from moral distress. I am so anxious to have the recognition that nursing leaders are experiencing this too. As the nursing leader for my unit, I feel I need to help protect front-line nurses. That being said, how do I care for myself so I can take care of them? It's an expectation that as the manager or leader you are supposed to be multi-talented and capable. We are human too. We have to multiply our moral distress by 175-250 times, which is how many staff I oversee. It's not only what you are feeling but also what staff is feeling. That can get heavy and is different from what front-line nurses' experience. (P14)

Another shared,

> I don't think the concept of moral distress that may be experienced in a leadership role is really recognized. I think people always imagine that the front-line providers feel moral distress about what they can or can't do for their patients at that moment in time and I think they feel that it's assigned to them by perhaps people as managers or in leadership roles. I don't think people recognize that it's difficult for leaders too, to see your team members or see patients not getting as high-quality care or as timely care as they could because of situations that we can't control either. (P24)

There was a consistent interpretation of the significance and implications of constraints imposed from organizational and government directives. Many participants reported dealing with

constant crisis management in navigating multiple simultaneous responsibilities amidst multiple patient/family members, inter-professionals, and societal expectations. Adding to these competing priorities were organizational and government mandates that leaders were expected to implement, often with limited (or without) input in decision-making, excessively short turn-around response times, and evaluation where "targets and time frames are given without understanding" (P21) or consideration of other deliverable initiatives. In addition, some shared their perception of these processes being driven by executive leaders in finance or other allied backgrounds within the organization without the consultation of senior nursing operational leaders, consequently excluding the nursing voice from the impact to delivery of patient care. One of the interesting elements associated with these constraints, as some participants reflected, was the perception held by front-line staff that leaders turn a blind eye to morally distressing situations within the environment (Dodek et al., 2016; Gaudine et al., 2011; Pavlish et al., 2016). Several participants at the managerial and director level reported this same experience of turning a blind eye by their senior leaders. They reflected on how and what they could have done differently to support the issue but eventually understood the constraint within the system was insurmountable due to specific mandates (e.g., organizational, political, or governmental) and lack of financial resources. One leader's frustration was front-line staff's perceived lack of understanding of these perceived strong constraints within the health care system and the resultant complexity of decision-making required of leaders to enact because of the dictated mandates. For example:

> I think the biggest message I would like to give anybody, particularly people that work under me and not in a formal leadership role, is that some decisions are not easy for managers. It may not have been the absolute best decision but it was the best decision we could make given the choices that we had. I wish they would understand that not every decision is made lightly or flippantly and that we know we have distressing situations related to patient care and staffing resources. (P2)

While ubiquitous, participants reported that moral distress is not constant; it is situational. "It might not be everyday or all the time," said one. "I think you come in and out of it. I don't know how you can work in health care and not at some point as a leader dip down into that. I think all leaders experience it" (P17). Most indicated that intensity and frequency were different for individuals based on their experience level, personality, program responsibility, and proximity to patient care needs. As one executive nurse leader stated, "Moral distress is different at different levels. I am sure my own moral distress of balancing finances and initiatives is different from my colleagues who are more operational than me. It's also hard to say I have more moral distress than my colleagues as I don't know what their experience is like" (P19). One consistent belief shared by all participants was that those closest to the patient, such as middle nursing managers, were more susceptible to moral distress due to the proximity to the patient (e.g., being responsible for the environment where the morally distressing situation occurred and seeing and feeling the emotion of the patient) and the span of control of the role (dealing directly with those who care for the patient). As one participant stated, "I feel for them [the managers] and I see the struggle. They are more at risk as they hear many more stories. They have hundreds of employees reporting to them about their issues [with patient care] and moral distress which they share with the manager" (P7). The middle manager role was viewed as the link to the human experience with these leaders responsible for guiding complex patient care situations that "tug at the heartstrings" (P2). Another spoke of manager's proximity to the patient, sharing:

> We are at the front-line, and I consider myself part of the front-line, driven by the patients that we see face to face. I think the further up you go in the organization you lose the face of the patient, you lose the connection with that patient, so the people making policy don't see it through the patient lens and I think that gets lost in the transition from a policy right to the patient in front of you. (P1)

While it was generally understood that moral distress was more prevalent at the middle manager level, every hierarchical level of leadership was identified as susceptible to moral distress. Several participants (directors, executive directors, and senior operating officers) shared they also experienced or observed the phenomenon at higher leadership levels. The context of the moral distress within these senior roles centered on more meso and macro-level elements such as organizational pressures regarding fiscal management, government mandates and initiatives, strategic planning and policy direction, complex patient complaints, as well as how their managers were coping with ethical situations and the constraints that were creating moral distress for them. For some participants, the higher one was on the leadership ladder, the less present or visible moral distress was, with triggers being different; it was believed to be different at a director, executive director, or vice president level. For example, one manager described her perceptions of the differences in moral distress at different levels, "We are the front lines and are driven by the patients that we see face to face. At higher levels, I think they are driven by a different moral compass. They are driven more by a financial or political one" (P1).When one director was asked if leaders above her experienced moral distress as intensely as she did, she replied:

> I think moral distress is primarily sort of managers, directors, executive directors but it seems to be less at the VP level or maybe less obvious, certainly less at the senior executive level. Recently I haven't heard anything about moral distress from the CEO or VP level, which fascinates me considering the task [reorganization] at hand. I've heard some quietly from the executive and certainly from the directors and some from managers but I do think there is a bit of a culture of best not to talk about it, best to just move on. (P5)

Thus, participants appeared to share an understanding that moral distress extends across all leadership levels, with middle managers being more susceptible to it due to the proximity of patient and span of control at the micro-level of the organization. While moral distress was

visibly present at the managerial levels, the higher one went in the hierarchy, it was not as visible, although still believed to be present. When reflecting on the differences in perception at different levels of hierarchy, there was a common understanding that while the ethical situations may be different, there were similar doubts or questions these leaders felt during the experience: How do senior leaders want them to perform? Do they have the same vision? Do they have the same style of leadership/perception? Do they believe the same? The similarity shared at all levels was a desire to perform their ethical professional responsibilities as a leader successfully in lieu of the morally difficult situation and moral distress experienced.

Finally, participants emphasized that there was a leadership culture of repressing the experience of moral distress and not talking about it. All participants acknowledged the omnipresent nature of moral distress yet alluded to a hesitancy to openly discuss the topic in daily practice. This was attributed to the perceived need to be stoic or the stigma and vulnerability it could create for leaders and their professional careers.

> Moral distress is present but not spoken about a lot. It's because of the culture. So many times you're told to do more with less or you hear comments like 'It is what it is.' I think people get that feeling that you just have to buck up and get it done regardless of what you feel needs to be done or your workload. You feel backed into a corner to at least get done what is required even if it's not necessarily the way you would have liked to go about doing it. (P29)

External and internal constraints prompting moral distress in nursing leaders. Within nursing literature, three primary underlying causes of moral distress have been identified: external constraints, internal constraints, and the clinical situation (Ferrand et al., 2003; Hamric, 2012). As expected, the findings in this study did not reveal new causes although it did reveal further knowledge from a leadership perspective.

In this study, participants discussed two categories of cause—external and internal constraints—within the Canadian health system. External sources of constraint were the most

prevalent situations identified including labor relation issues, system tensions, large-scale organizational change, span of control, and community and societal variables. Internal constraints (meaning internal personal characteristics to the individual) included fear, powerlessness, silenced voice, and isolation. Table 4.3 summarizes the two primary categories (external and internal constraints) of causes of moral distress shared in this study. What follows is a brief examination of participants' experiences of these constraints.

Table 4.3.

Categories of Cause, Patterns of Situations, and Morally Distress Elements/Dimensions in Nursing Leaders

Categories of Cause	Patterns of Situations	Morally Distressing Elements/ Dimensions
External Source of Constraint:		
Labor Relation Issues	Staff Performance/ Competency Management of Narcotic Theft/ Criminal Acts /Sick time Business of Organizational Risk Interaction with Labor Unions and Interpretation of Collective Bargaining Agreement	• Occurrence of adverse patient event • Availability of time and delay in follow up • Disappointment in the employee's professional performance and/or moral incongruence of the allegations against the employee • Leaders moral connection and action to the event • Assumptions and conjectures over leader actions during the investigation • Maintaining confidentiality and inability to justify actions • Lack of organizational documentation and leadership follow- up • Hesitancy of employee reporting/documentation • Organizational lack of support to uphold performance management decisions • Perceived lack of power, knowledge, and fear of interacting

	Staffing Resources/Care Models/Scope of Practice	with labor union unions. • Lack of support from organizational and regulating bodies. • Lack of organizational transparency in delivery of new initiatives
External Source of Constraint (cont'd)		
System Tensions	Financial Constraints and Education	• Balancing and justifying escalating operational needs to senior leaders/government
	Care versus Cost/ Health Delivery Model	• Managing the escalating operational needs of patient care (aging population, increasing patient acuity due to chronic disease, and limited community supports) and the organizational expectation to meet the set budget. • Burden of potential blame regarding expectation, fiscal accountability and risk management. • Lack of initial and ongoing financial training
	Human Resources	• shortages and/or imposed organizational policies limiting access to staff (i.e. overtime ban; fatigue policies) • Inability to facilitate timely care for patients within the right care area.
	Hospital Inpatient Capacity	• Barriers to available resources (i.e. inpatient beds, staff, or community resources) due to silos and financial targets • Daily organizational risk and patient safety issues associated with limited acute care capacity. • Conflicting elements of capacity, values, and shifting care back to families and the community with limited patient supports (i.e. family support, housing, financial, and safety issues).
	Lack of Master Organizational Planning	• Lack of master organizational planning by previous leaders and government • Not being recognized for clinical excellence and being shut down.

Categories of Cause	Patterns of Situations	Morally Distressing Elements/ Dimensions
External Source of Constraint (cont'd):		
Large Scale Organizational Change Done Poorly	Impact of Reorganization & Leadership Change Change Management Importance of Communication	• Perceived organizational secrecy and lack transparency • Inconsistent/lack of communication • Lack of shared vision from the Chief Executive Officer. • Fear • Perceived loss of prior relationships • Organization treating leaders disrespectfully
Span of Control	Workload Insufficient Time Exclusion from Decision Making	• Not being able to do a good job • Availability of time to understand an issue • Failure to meet personal professional, and organizational expectations • Impact on relationships
Community/ Societal Values	Unmet patient or family needs/expectations Government or Media Involvement in care Significant Societal Events	• Observing staff suffer over unfair accusations • Media biases • Inability to defend staff when the organization's actions were standard protocol. • Pressure from local governments and the organization to diffuse the issue. • Access to available policy • Workload • Availability of resources (human and equipment), education, and ensuring employee protection and safety
Internal Source of Constraint:		
Fear	Job Loss Failure Inadequate Negotiation Finding Solutions	• Failure • Cannot afford values • Not being heard • Perception of incompetence or no control over team • Competition and relationship • Held hostage by labor unions

	Resolving Conflict Incivility and Violence	• Fear of not knowing what to do but knowing you have to make a decision • Fear of doing harm
Internal Source of Constraint (cont'd):		
Powerlessness to Act	Complex Environment Complex Ethical Situation Disagreement/Lack of Support of Supervisor/Organization	• Weak moral leadership competency • Medical futility and end of life decisions • Complex medical or social discharge planning • In-patient capacity issues and availability of community resources • Organizational process and new initiatives • Disagreement with their supervisor • Not being heard or perceived to be supported • Perception of being ineffective as patient advocates as they are not able to support and instigate change within the organization.
Silenced Voice	Supervisor Behavior	• Impacted confidence level, • Not feeling heard or appreciated. • Impacted employee-supervisor relationship • Increased self-doubt perpetuating imposter syndrome • Organizational culture impacted in a negative way. • Underlying tone of oppression, violence and personal risk when leaders are silenced.
Isolation	Isolating work	• No easily available referent group • Lack of support from HR resources • Lack of support from their supervisor • New to the organization or role

External constraints prompting moral distress. The Canadian health care system is a dynamic, unpredictable, political entity filled with many tensions (e.g., financial, resources,

capacity, and political) exerting enormous pressure on those working within the system. There were five external sources of constraint participants emphasized that created moral distress in their roles as Canadian nursing leaders (Table 4.2). While not an exhaustive list, participants identified the following.

Labor relations issues. Participants consistently shared labor relations situations as one of the key triggers of their moral distress. Staff performance or competency adversely affecting patient care was one example. One leader shared an instance where a patient had an adverse event based on the lack of action of the nurse involved. The leader's moral distress was related to the adverse event itself: the delay in being able to follow up with the nurse in a timely way, feelings of disappointment in the nurse's professional performance (perceived laziness), and the need to protect the reporting nurse who brought the situation forward. An interesting element that was reported to have contributed to the moral distress was the leader's moral connection and action to the event, as noted by one participant:

> Do I play some part of not dealing with this employee regarding her sliding practice six months ago? I heard rumblings on the unit but nothing concrete. Could the scenario have been different and do I own some of that? I probably do own the fact that if I didn't have 250 people to keep track of or if she had had a regular performance review, would she have gotten into this pattern of nursing care? Morally that is my issue as I wrestle with the fact that I own some of what happened to that patient. (P1)

Another leader shared a unique situation that created moral distress when managing and investigating a staff member's inappropriate and criminal behavior. The complexity and time required for the investigation was described as "large and isolating" (P4). Factors that contributed to the leader's moral distress included the moral incongruence of the allegations lodged against this well-respected employee. Further dissonance occurred as stories, assumptions, and conjectures were made by staff about the leader's investigation. The burden of

maintaining confidentiality (professionally and organizationally) and the inability to justify her actions during and after the investigation compounded her feeling of moral distress.

> I had to fire somebody which we know is not pleasant, but there were police charges related to a potential sexual assault of a vulnerable visitor and staff member. We had to do quite an investigation. The nurse was well liked by his peers. The hardest part for me was that the unit was really angry. They were actually yelling at me saying that I railroaded the nurse and ruined his career. The staff didn't know that I was the one, when the doors were closed, breaking down and crying in front of the union and HR over the shock and disbelief. About a year later, the employee's license was revoked and the employee was charged with sexual assault. A couple of staff came up and said we heard on the radio today and we're sorry. As a manager in these situations, you can't give any information. You've got to take it like an idiot, understand you are persona non grata for a long time where staff and colleagues may never find out all the nuances. (P4)

While the above example is an extreme case of performance management, many participants had similar experiences. Another morally distressing performance issue shared by a number of interviewees was narcotic theft by employees. These constraints included lack of organizational documentation, lack of leadership follow-up, hesitancy of employee reporting/documentation, and maintaining confidentiality. One reflected,

> This employee had been on repeated return-to-work plans (seven times in a four-year period) where organizational documentation was limited to mental health issues. Several employees were coming to me with various concerns like 'she seems space out, she went looking for the pop machine and she never returned'. There was no documentation by employees only 'concerns' so I actually had to tell staff to document them for me to move forward on these concerns. When I met with employee the distress I had was hearing her tell me I had just ended her career and that I was leading a witch hunt. She would say to me I'm leaving the profession because of you and as much as I try to keep things confidential when she posts things on Facebook. It's a he said- she said and I can't say anything. The employee is off now, which is the safe thing, but she is going to be back so how do you keep doing this over and over again. I guess it's very much like drunk drivers, how many times do we take them off the road. It feels quite helpless. As long as they can get the right doctor to give them the note that they need I can't do anything and that's the challenge because if the employees themselves do not acknowledge or accept they have a problem, it's a cat and mouse game. This has an impact on other staff members. They don't know all aspects of the story and you can see some hesitation or pulling away of a few that are normally engaged. People start thinking I better watch my back because if you are attacking her, what about me. (P14)

Another prevalent labor relations constraint mentioned by many participants was employees' perceived abuse of sick time benefits and the ripple effect it had on others. One participant shared her frustration and experience of moral distress after following up on an employee whom she strongly believed was abusing her sick time benefit. She stated,

> People will call in sick and then you see pictures of them at a party (if another staff member will give you access to the restricted staff Facebook page). As a manager you try to discipline and deal with them and they win out in the end through a grievance even though you know the employee was in the wrong. It's the system that we work within and changing that culture requires more than just me. . . . especially when I have over 200 employees to monitor. (P10)

Moral distress was also triggered in the management of employee sick time. Leaders expressed a belief that they were perceived by employees and the organization as not taking action when sick time abuse occurred, but this was not the case.

> One of the situations when I talk about staffing is the staff's perception that I never do anything about replacing staff. First of all, that is wrong. Second, I just had an employee go out and say we might as well just call in sick, it doesn't matter anyways. I had a shift with four people who called in sick because one person said you can't make me come to work if I need a mental health day and she got her little gang and we had a shift with no staff coming in. Other staff then capitalize on overtime because everyone knows that person is going to call in sick or they don't want to work short-staffed. . . . it becomes an unethical game. (P14)

Another labor relations constraint identified as triggering moral distress was what one participant referred to as the business of organizational risk. Several participants reflected on the moral distress that was triggered after complex labor relations cases involving wrongdoing of employees who were then paid out by the organization to unions or employees to avoid arbitration. For some, being asked by human resources (HR) to approve pay-outs was perceived as a professional violation of not advocating for patient safety or care. For another, frustration was verbalized over the moral incongruity of this action after the organization had conducted a thorough investigation. As one participant shared,

> I think the moral part for me that really bothers me is the pay-out that we have to sometimes do to employees even when the evidence we have gathered in our investigation clearly outlines that the employee was in the wrong or incompetent. This adds salt to the wound especially when patients' lives are at stake. The union fights for the employee regardless of patient safety and they want money. Why did HR tell me to carry out the disciplinary actions when we were going to revoke or pay out the employee in the end? It doesn't make sense. The union has so much power it just doesn't seem right. So now we're paying the employee off, the organization just want them out of our hair and avoid arbitration or any court cases. It didn't feel right. (P4)

Other triggering events prompting moral distress involved interaction with labor unions and/or the interpretation of Collective Bargaining Agreements (CBA). One participant shared her perception that there was an underlying fear held by many nursing leaders that was rooted in a perceived lack of power within the role and lack of knowledge required to work with unions. This labor-related constraint was echoed by others, allowing an interpretation that there is a level of expertise and education needed and desired by nursing leaders to be able to negotiate the complexities of clinical situations and the ever-present tension between the employer and union, both of which often trigger moral distress. One senior leader shared,

> That is distressing to me too because we become held hostage by the union. You have to be able to stand up to the unions and tell them what you are going to do as an employer because I'm actually responsible for the patient care. You really have to get a firm handle as a leader. It's not that I don't want to work with them but if it affects patient care and their unionized member is not performing and causing issues with patient care and just the overall well-being of the unit by calling in sick, everything needs to be dealt with. People need to know you mean business. So, I think the unions cause me moral distress because then staff start threatening you with I'm going to call the union in. Well you know, just do that because I'm not afraid of unions, I'm just not. We have to protect patients and the union is focused on protecting the employee regardless of huge practice issues. (P7)

The difficulty of interpreting CBA was another union-related source of moral distress for nursing leaders. For example, one participant shared how denying an employee's special leave created significant moral distress for the leader, the employee, and organization. The decision to deny the special leave was based on the leader's personal spiritual value system and her interpretation

of the CBA at the time of the incident (death of an extended family member's unborn child). The employee grieved the decision. The interviewee felt the lack of support from the organization (through HR resources) as well as other professional sources of support such as regulating bodies, caused the moral distress. Other participants similarly mentioned the frustration that lack of support from regulating professional bodies has on nursing leaders' moral distress, especially when the situation involved scope of practice concerns and navigating the right approach to performance management. For example:

> Say it's a simple performance issue; let's say it's a nurse who is always making basic errors giving medications. Well how do I go back and teach her an entire nursing degree again but it's like you've got to navigate that with your association and create a learning plan for them which you know won't be successful as the core knowledge isn't there. Somebody help me here! Am I ok according to my practice for my association, am I ok according to law. I'm not a specialist in all these things and I can only do my best. I do not want harm anybody or my practice or any of my nurses. I can have those professional guidelines and standards on my department but it doesn't mean I'm the expert. I need somebody [in the professional regulating body] to validate that sometimes. (P30)

One final labor-related constraint mentioned was how staffing resources, care delivery models, and scope of practice issues could impact nursing leaders. One leader shared that she was instructed to deliver a new care delivery model that would impact the nurse to patient ratio on one of her acute medical units. Her moral distress was due to the secrecy and lack of transparency demanded by the organization in the implementation and rotation changes that would result in job loss. The moral incongruity for this leader was in knowing about the upcoming change and how it would impact the employees on her unit, especially when one of the nurses who would be affected had just informed her that she was purchasing a home. In another example, one leader shared that her unit would be releasing/displacing licensed practical nurses (LPNs) and replacing them with registered nurses. She communicated that the morally difficult element was that she felt that she would jeopardize the LPNs' confidence in their care

and would let the group down by not being able to come up with a solution that would work in the unit.

System tensions. The most prominent external constraint producing moral distress identified in this study was the fiscal constraints within the current Canadian health care system. Many reflected on a rapidly evolving new care delivery model as the root cause of this constraint. The traditional model of evidenced-based care was perceived to have shifted to a reductionist paradigm of cost-effective and efficient care within Canada, driven by government mandates that had many participants suffering.

> We are responding primarily to Ministry-driven objectives that are financially motivated versus being best practices. I see distress amongst the managers and other leaders, even senior leaders above me have taken me aside and have spoken about how morally distressing their job is and they start to have stories around that. This creates a feeling of malevolence within the organization especially when it has to do with patients. (P16)

The shift to a business-centric model was viewed as making it harder for leaders grounded in providing best patient care to be able to do the jobs that they were hired to do and the need to find support for the patients and their teams. Leaders expressed distress when they had to make choices about what to do with limited funds and expressed further concerns as the financial constraints increased.

> Moral distress is going to increase because decisions will have to be made that healthcare can't stay the way it is because it's financially impossible to keep up. Senior leaders must figure out some way of finding a balance to provide the care to support the people who have been entrusted to do the work yet being able to be fiscally responsible. I think that is the moral distress of the future. (P1)

The morally distressing elements associated with these patterns were emphasized to be balancing escalating operational needs with allocated fiscal resources and justifying the variances to senior leaders/government. Every participant poignantly described the reality of escalating operational needs of patient care (e.g., aging population, increasing patient acuity due to chronic disease, and

limited community supports) in conflict with a highly resource-constrained environment and organizational expectations to meet the budget. The constraints of doing more with less within the health care system and its myriad implications were a concern expressed by all participants. Common among the accounts was the organizational or government expectation between fiscal accountability and risk management and an underlying burden of potential blame directed at the nursing leader. The tension and implied responsibility and accountability were emphasized multiple times. For example,

> I am held to getting my costs down and at the same time I have to care for the patients - the critically ill and injured and if I don't bring in those staff at overtime we won't care for those patients. You can rest assured if there is one critical event, somebody's going to be saying, 'Well why didn't you, we didn't tell you not to, we just told you to look at your budget.' Really, you're getting a mixed message. (P21)

The challenges of financial decision-making and accountability in a constrained resource- dependent environment were compounded by the lack of initial and ongoing financial training for nursing leaders. Participants consistently noted the absence within their profession's academic curriculum regarding financial education. Nurses are taught the practice and art of nursing, not business or finance. While clinically understanding what nursing or patient care resources are needed to deliver quality and safe care, navigating the financial procurement of the needed resources can be daunting.

> We are not handed a manual when you become a manager to understand how finances are done, so you learn all of that on the job or you go to school after the fact and train for that. As a nurse leader it's what I call OJT, on-the-job training, unless you've actually decided to pursue your master's in business administration or health administration. Schooling costs a lot so if you come from a background where you may not have the opportunity financially to do that education, that is a constraint as well. It's having the knowledge base to be able to navigate how to get things done and how to advocate for the resources that you need and in listening to other nurse leaders. (P19)

A second system-level constraint identified is associated with human (staffing) resources and acute care inpatient capacity within the health care system. The ethical concerns regarding

staffing resources were either due to shortages and/or imposed fiscal constraints such as not supplying additional needed baseline staff and organizational policies on overtime or employee fatigue. As one participant stated,

> When you have staff telling you they are not staffed appropriately, filling out profession responsibility forms and safety/quality learning events that is difficult for me. [I know] as a nurse the quality issues, the morbidity or mortality of the patients could be related to the lack of safe staffing on the unit. I can feel the distress of the nurses because they want to come to work to do a really good job, that's inherent. It distresses me when I see them distressed and there's only so much I can do about it. (P11)

Participants shared conflicts and constraints felt around acute care inpatient capacity and the ethical turmoil it created when staff and leaders were not able to facilitate timely care for patients within the right care area. In short, nursing leaders felt moral distress when confronted with limited in-patient bed availability to care for patients. The intensity of moral distress was accentuated for participants when they observed or perceived other leaders controlling access to resources (e.g., inpatient beds, staff, or community resources) based on an individual program's fiscal accountability versus patient need. Caring for patients in hallways (usually identified by those responsible for emergency departments) was consistently expressed as creating moral incongruities for leaders within their ethical practice and clinical reality. As one leader stated, "That to me is very distressing—when I see the staff distressed because of congestion and the care that they can't provide because of being congested and being overworked because of too many multiple priorities. Canada isn't a Third World country, yet we are providing care as if it is" (P7). One of this leader's underlying elements regarding extreme overcrowding in the emergency department (ED) was due to a sense that the organization and health care system defaulted the systemic issue of capacity shortages to the ED. "It's much cheaper," she stated, "to care for a patient in a hallway than it is to regularize added beds on a unit" (P7). This leader

went on to share that while the culture is slowly changing—silo thinking still occurs where ownership of patients is still disputed.

> For instance, a manager wrote today and wanted to close four beds on an inpatient unit as they were over census and her director was pressing her to close the beds to save money. I had just been down to ED and I said, 'Well, we're still caring for people in areas that aren't conducive to their care and we are still going to see 450 patients today. I know it seems small closing four beds but until Emergency is functioning and able to handle their flow all day, no, closing beds isn't really an option'. I get frustrated when people become myopic and forget we are a system. To me it's like, how about if you were a surgeon and you went into the OR every morning to do your job and there were already people on the operating table that they haven't been able to get out yesterday to a bed. How would you be able to perform the work that you were hired to do today? That won't be tolerated. So to some extent emergency has lost their voice. (P7)

The lack of acute care capacity and its link to moral distress was described by several participants. Participants verbalized the daily organizational risk and, more importantly, patient safety issues associated with limited acute care capacity. Significant adverse patient events and even death were noted to be occurring as a result of capacity issues and consequent decisions:

> We had a patient transferred to us from a community referring hospital. The nurses at the sending site recognized the patient was acutely ill and got him over to our halls. He sat in the back hall with the ambulance because we had no space and was initially seen by the physician. It was busy in the department and the patient spent several hours in our hall. It was at shift change when we got the patient into a care space and within a half an hour the patient arrested and died. It's overwhelming. The patient outcome was the morally difficult element compounded by the physical environment and the expectation that we are available for all programs for all people where our doors never close. That should never have happened and hearing the region say we need to make improvements before something bad happens. . . . I just want to jump up and down and scream something bad has already happened and more will continue to happen. It's the lack of acknowledgment that we cannot continue in this way and not recognize that. That projection that something is going to happen has already occurred and will continue to occur until something is done within the system. (P14)

While many of the participants spoke passionately of capacity issues related to the front end of the acute care system (e.g., ED overcrowding), others reflected on the impact of their decision-making in these ethically difficult situations and the downstream impact it would have on patients, colleagues, and other organizations or facilities within the system. For example, one

participant reflected on the moral incongruity she experienced when she was confronted with decision-making regarding an adult protection case. The case involved abuse of a geriatric patient that would result in the patient's placement in a long-term facility. Within the health care system in which she worked, patient placement due to social circumstances can take almost two years. In this case, the participant knew that she could circumvent the system by keeping the elderly patient in the ED, where access to a community long-term care bed is significantly quicker (24 hrs–15 days). The moral distress for this leader was centered in knowing that this extended the stay for other patients who had already waited for a long period of time. A further compelling story illustrating the intensity of leaders' emotion due to this system tension is captured:

> It was relentless and that relentlessness was every single day. We were drowning in patients and we couldn't stop it, it was like a hemorrhage. We all were bloody and we had our hands on the wounds and trying to stop the bleeding. It's interesting because I'm a servant leader and I believe in the idea that my nurses and my staff, all of them, they care for patients and families directly, it is their job to serve patients and families. My job is to serve them and my director's job is to serve me and the VP's job is to serve the director. That is not necessarily how people see their jobs. I think that what we as managers felt was the sense of powerlessness in the Directors and VPs to whom we report and their sense that they didn't know how to stop the hemorrhaging. They would turn to us and say it's your job to stop it and we would be like I don't understand what you mean by that, I can't stop it. I can't get nurses because I can't hire them, you won't increase the baseline that I'm working with. It was like shit rolls down hill and we would say I'm sorry we don't have the staff therefore I can't take care of the patient and I would get pressure from my Director. The undertone is that you are not doing a good job as a manager if you have to close your unit, there is something wrong with you, not something is wrong with the system that is not allowing you to actually staff for that particular unit. The other piece is that in acute care, we have concepts of off service, so I have a cardiac unit and none of my patients could go anywhere in this hospital but my unit can take medicine, surgery, and psychiatric patients. I can take whatever on my unit, but the nature of my patient population is that nobody else takes them. We end up with all these off service and I have to close one of my heart-specific units because they've filled up my beds with patients that are non-cardiac. This gives you just the very visceral sense of what we were dealing with for the last six months. (P12)

Another example that also speaks to the capacity shortage across the continuum of care (e.g., residential and community care) is noted below:

> I know exactly what my moral stressor is. I run the Alternate Level of Care (ALC) unit in the hospital. I have managers and families phoning me all the time saying, 'We can't take care of mom anymore. She can't go home; she is 98, lives alone and is confused. Her house is full of cockroaches. She's drinking every night and falls every day. We've brought her to the hospital seven times'. All are sad stories but I say to the staff, 'Discharge her.' They look at me like I'm insane, like what do you mean? The reality is the patient doesn't need to be in hospital and is medically stable. We cannot keep that person here because we've got another sick guy in emergency that needs the bed. That causes me a ton of moral distress. Sometimes I think am I that uncaring? Yeah, sorry I'm crying. My brain knows what we need to do. I can rationalize it in my head but there is a disconnect between really wondering if that's right. The weight of that responsibility is huge as a leader. I feel like I've become this really callous person. (P23)

In these examples, the moral distress is found in conflicting elements of capacity and values and in actioning/shifting the care responsibility back to families and the community when there are limited patient supports (e.g., family support, housing, financial, and safety issues). The emotional intensity and sense of powerlessness created by these organizational constraints was noted by many participants.

A few participants spoke about the moral distress created for them by the lack of foresight and planning by previous senior leaders within the organization and government, regarding redevelopment and master planning (e.g., planning for staffing resources, equipment, process and flow). In one case, a participant shared an experience of being involved in the conceptual design and implementation of a new critical care department. The participant repeatedly attempted to explain to the project steering team the resources needed to operationalize the unit on opening day, but she was consistently shut down by other senior leaders who were removed from the day-to-day clinical operations. At one point she was told to 'Shut up or lose your job.' The morally distressing elements were knowing the design team was not focused on doing the right thing for patient care, and how devalued the team made her feel

every time a critical future operational issue was brought up. She stated, "I felt like this job was going to kill me" (P17). As the project neared completion, executive leadership acknowledged that her recommendations years before should have been implemented and that the critical care area could not be opened without them. Another poignant example of moral distress created by poor forecasting of operational requirements included the implementation of electronic charting in one ED:

> They had never budgeted or engaged in conversations around the operational impacts of financial and human resources. When they did, they said we will deal with it later. Well, we went live with our new department and the electronic health records without the human resources. It was nuts. In the first few weeks of opening, I would go home crying because I knew we didn't have the right resources or supports in place to deliver safe patient care. (P19)

Political complexity of the health care leadership climate. One of the trends within nursing research is exploring how the organizational environment influences the moral decisions and outcomes for individuals working in those environments (Gaudine et al., 2011; Lutzen & Kvist, 2012; Musto et al., 2014; Pauly et al., 2009; Silen et al., 2011). While several participants shared how they believed the environment in which they worked was positive and in alignment with their own professional and personal values as a moral agent, the majority spoke of the challenges and negativity within their work environment that has influenced their decision-making in certain ethical situations. In these participants, the political complexity of the health care leadership climate was identified as a significant source of moral distress. Participants acknowledged they were acutely aware of a potent political culture within the organizations in which they worked and spoke of it openly in their examples of moral distress. In particular, they discussed the presence of politics, biases, and poor leadership tone.

Multiple levels of politics within the Canadian health care system were perceived to contribute to the complexity and navigation of ethical situations. Participants noted politics occur

not only within the local hospitals and communities (which has several levels of politics/relationships among physicians, nurses, staff, administrators, and community sources), but also at regional and provincial levels. Several participants described this culture as "a dangerous world we are always navigating" (P5) and "Love everyone, trust no one" (P1). A number of participants expressed a feeling of isolation in situations of moral distress, which was matched by their recognition of the strong need for and value of political acumen for those in leadership roles. What is interesting was how quickly one becomes aware of this as a leader. As one new nurse leader participant explained,

> I have been formally in the manager's role for a short time. I quickly found out within a few weeks of assuming this role how political it was. It's been extremely challenging navigating the political environment in the realm of leadership and there's really nothing that prepares one for that, that's how I felt, and I have had mentorship but sometimes that doesn't help. (P13)

A variety of biases and forms of discrimination were also identified within the political culture of leadership that contributed to constraints within participants' roles and the experience of moral distress. Gender discrimination created moral distress for some nursing leaders. One male participant reflected on his relationship with his current supervisor by stating, "She seems happy to be a female managing a male, that's just my perception. I just don't feel comfortable going to her to unload how I really feel" (P2). Navigating and managing morally distressing situations in the clinical environment amidst the fear of gender bias can lead to feelings of isolation and lack of support. A female participant leading in a rural health community also spoke of gender discrimination as well as the historical physician/nurse professional bias present within the health care system. She noted she was initially blind to the underlying discrimination present within the community of care that she was leading, which, on reflection, contributed to several situations that created moral distress for her.

> My province still has that good old boy mentality. There is still a gender-related and a physician-related bias in the system. I hear comments like, 'You're just a little lady from the city,' or 'You're only a nurse." When I first started I was completely dumb about politics and I have to tell you that I probably didn't even notice the influence and resulting constraint until my second year. For example, we would invite a mayor to come into a community board meeting and often they're men, and they would come in and I would be the senior person. They would shake the hand of the site administrator--a man. They may not know him but they would go immediately to him and completely ignore me. I thought that is so weird. I would do the presentation but the questions were always directed at the site administrator, rarely to me. It took me 18 months to figure out this barrier and I was gob-smacked. I experienced a similar situation in an urban setting but it was more a doctor/ nurse administrator bias where they would be very disrespectful. I'm still struggling to make sense of it but I have to shift how I feel about it. I have to let it go, realize that it's culture for them and kind of have that pioneer spirit and not let that get under my skin. I am in a position of leadership and so I have to lead by role modeling back to them how to be respectful to one another. (P25)

One last element of the political culture that created moral distress for nursing leaders was the tone set by senior leaders, specifically one that was transactional and hierarchical. Several participants who had recently gone through a reorganization discussed the importance, implications and impact on the leadership team:

> I think there are a couple of tones of leadership. At the very top levels I would describe the tone as black, I'm going to try and explain that, lacking compassion and insight, the word I want is transactional. I think there is some transformative thinking occurring but it's being enacted in a transactional style void of input and hierarchical in nature. At the second tier of leadership, executive director, director, manager level I think there is a sense of demoralization set by this tone and their tone is cautious, distrustful and disengaged at this point at multiple levels. The ministry set the outcomes; they didn't identify the process and they certainly didn't identify the type of leadership to do this in the best way possible. (P15)

In the context of what it feels like to interact within the political leadership culture of health care, there were a variety of responses including struggle, demoralization, frustration, powerlessness, and fear. Participants expressed that "Many days leadership feels like an uphill battle" (P15) due to the politics tied to health care and the changes that continue to happen within the provincial system. Other participants discussed the loss of and respect for memory. In essence, what is old is new again. As one leader stated,

> I feel demoralized and of course you can tell I've been here a long time. I have corporate memory, which many people don't. The people who are my senior leaders are all brand new. I have been here so long I can actually say to them we tried these things and here's what failed or we did this but here is what the problem was and so we just keep coming back. It's frustrating when senior leaders don't listen to the corporate memory and silence it. There are many long-standing problems where the solution (increased capacity) would resolve it but no one wants to listen. Not sure how else I can tell you that the capacity issues have been here for decades, and it's now 2015, and we haven't fixed that yet. (P21)

Large-scale organizational change done poorly. Over half of the participants attributed poorly executed large-scale organizational change as a trigger for moral distress. The morally distressing elements attached to this experience included perceived organizational secrecy and lack of transparency in restructuring, inconsistent or lack of communication, and lack of shared vision from the chief executive officer.

> We are currently undergoing a very rapid reorganization in our health region and I think many senior leaders are suffering moral distress as they see the rapidity in how it's being rolled out, by the way it's affecting people, and what is ultimately going to be asked of us in cutbacks because we have a huge deficit that we have to address. (P5)

While participants understood the importance of urgency of large-scale organizational change, they were very clear in their experience of dissonance regarding perceived ineffective implementation of change management strategies. In addition to the morally distressing elements identified above, a ripple effect of fear is generated by reorganization along with the perceived loss of prior relationships (replaced by new ones) among leaders throughout the organization. Many focused on their feelings and observations of the impact on leadership relationships and the difficulty individuals had navigating these relationships during the reorganization. For example, many participants observed other leaders being treated disrespectfully:

> Well, right now, in our own organization it's the organizational change that's occurring. There are a lot of our leaders who are distressed because again leadership is political, so you're seeing people being placed into positions not necessarily based on merit but based

> on leadership styles or relationships/friendship. We all have different styles and we all can be very effective and I get it to a certain extent, but when you have leaders that have been in a position for five years and then all of a sudden just because the top is changing they no longer are good enough for the position that they have been doing a great job in. The uncertainty within leadership positions is huge. (P3)

The lack of transparency, inadequate communication, and lack of shared vision were reorganization pitfalls that participants felt created moral distress. Several shared how secrecy created morally distressing situations either through lack of information being shared or being expected to keep quiet about impending changes. Many pointed out that when there is a lack of communication, people start to create their own stories, especially when there is high attrition of senior leaders who were respected in the organization as ethical people.

> This new reorganization is the most hush-hush thing. You can't talk about it and you get the information from the strangest of mechanisms. No one knows what is going on. Just be transparent, whether its communication, or the vision. I think that you can't be the leader you need to be if you're not sure what vision you want us to lead. (P1)

Some study participants perceived that staff observed the leader's moral distress throughout the process. "They wondered whether they will still get the support they have had. I think some of them are genuinely concerned for me, and wonder, is my boss still going to be here? They look at you and they're morally distressed by what they see going on around them" (P1). Participants emphasized that during organizational change, direct patient care was minimally impacted, emphasizing the system "moved slower than normal" during this period of uncertainty and moral distress.

Span of control. Leaders' span of control was identified by almost all participants as a dimension that adds to and occasionally creates moral distress. The span of control in this study ranged from 25–2,000+ employees, with the nursing leaders consistently identifying workload, insufficient time, and exclusion from decision-making as situations causing moral distress. Among these, workload was the most prevalent cause of concern because it meant a perceived

failure in meeting personal, professional, and organizational expectations of responsibilities. Specifically, the tension and constraints associated with a span of control focused on the leaders' ability to have frequency, depth, and quality of interactions/relationship with employees in order to support them in their work. One participant described, in a poignant metaphor, her view on her span of control and workload:

> I manage 250 people. How? I'll make sure that the countertop is perfectly clean but I don't often get to open the drawers. That's my current reality and job. I know 250 employees, I know their names, I know the work they have, and I know a bit about their personal lives because that's important to me. Should I sit down with some of them around their practice more often than I do except-yes! That's the real dilemma for me because I think if we spend more time at the early levels when we have a couple of little things that are happening around practice we could avoid the bigger events. Again, there just aren't enough hours in the day. (P1)

Another span of control issue was a perceived disparity of workload between mid-level managers and more senior leaders, as well as variations across health programs. Simply put, participants believed the manager's workload was greater than that of senior leaders, and that those in leadership positions (managerial) with dynamic variables and acuity, like critical care or emergency, had the largest workload. Several participants compared the perceived disparity of the health care sector with other industry sectors regarding leadership responsibility and span of control. Concern was expressed over how health care, which is one of the most complex industries where ethical situations occur on an hourly basis, continued to support unrealistic spans of control:

> I think the organization really needs to look at portfolios. The manager who has 20 full-time employees (FTEs) is going to get those performance evaluations done, the one who has 100 FTEs which is like 200+ people, forget it! It is unrealistic in our healthcare environment, especially when it is all so complex and with patients' lives on the line, to have so many employees reporting to one individual. Other industries don't do this or have that added level of patient complexity. Complexity demands time, and if the span of control is too broad as a manager, you have that distress because you can't do that diligence. Even if you do the diligence, something else has to give. (P8)

Within the constraints experienced with span of control was insufficient time as well as competing priorities for that time that created feelings of moral distress. This created feelings of not being able to do a good job despite a strong desire to do so, as well as not being able to spend the time required to really understand an issue.

Finally, decision-making related to span of control was taken very seriously by participants. Believing they understood their designated program/unit best and how the changes would impact the system, leaders expressed frustration when they were not consulted on major decisions. One participant shared such an experience:

> Somebody once again made some decisions without my ability to provide input. I was very conflicted with that and when I came back from holidays, I just tried to keep some money and staff to provide some continuity to the unit. It was incredibly distressing for me. I'm a very transparent person and there again what we are told in leadership is to be authentic, transparent, but then when you're doing some of this work you're told this is confidential, don't say anything to anyone. I literally had to hide in my office for a solid month, while all of this planning was occurring. I was sad, angry, and distressed over the moral incongruity and impact it would have on patient care. I could hardly go out to the units to see or speak with the staff because I was so conflicted, and they did perceive this conflict even though they didn't know what it was about. (P10)

Another participant reflected on the perceived frequency of being excluded from decision making within her organization, noting the impact on patients and within leadership:

> I have been involved in so many changes where I was not a part of the decision and the moral distress resulting from that has been two-fold, a) it impacted patient care adversely as I anticipated and b) it creates a culture of undermining and analysis paralysis because you don't know why you weren't asked for input when the organization apparently prides itself on seeking input. (P12)

Community/societal influence. The power and influence of outside organizational sources such as families, government, media agencies, community, or other larger societal sources were also identified as triggers of moral distress for nursing leaders. Of these, the first emphasized by participants involved unmet patient or family expectations. Participants shared the complexity of and skill required in working with patient-family dynamics. They

acknowledged how clinical situations involving acutely ill patients tend to escalate family tensions and underlying family dysfunction as direction and goals over care are outlined. Understandably, families want everything done and, at times, this is in conflict with patient requests or the health care team's recommendations on what is in the best interest of the patient. The stress can quickly turn to moral distress, especially if leaders must navigate very difficult ethical decisions involving access to resources or end-of-life decisions when they know they will be disappointing the patient or family. One participant shared how she grappled with the idea of knowing she was overriding one family's wishes when she first became a manager.

> I remember meeting every single day in the director's office with this very demanding family. We were trying to appease them because of threats to go to the media or their Member at Large (MLA). To me, it was like, what a waste of our resources and our time and it's like we are providing a positive reinforcement to this dysfunctional behavior. I see a lot of that in the complex family cases that I'm involved with. (P10)

While navigating unmet patient or family expectations of care was identified by participants as a challenging and complex part of their job, many described the moral distress they experienced when patient concerns became wider public discussions through government inquiry or media news stories. Threats of media coverage or involvement by government officials created significant moral distress for leaders.

> I found it really distressing to watch that story play out on television because we couldn't advocate for our staff. A story was told about a patient where the family validated it; the media believed it a 100% and we had no voice by which we could speak to or defend the actions of our staff or our hospital's reputation. Watching the staff suffer under that, shall we call it accusation, watching the staff that I knew who hadn't done any harm to listen to that repeatedly and watching it over and over again in the media and not be able to defend the staff in the media, not being able to say to the public this just didn't happen that way. All we could say behind these walls was we know you are a good person we support you, but it felt distressing to not be able to clean it up and tell the true story or address some of this negative media. (P5)

Significant pressure from the organization, media, or government contributes to the experience of moral distress due to the perceived sense of wrong-doing, incompetence, and blame directed

by these external sources toward the leader and the clinical environment. The morally distressing elements for leaders when patient care experiences become community discussion included observing staff suffer over unfair accusations, handling media biases and agendas, and being unable to defend staff even when the organization's actions were standard protocol. The other significant element participants emphasized was the added significant pressure from local governments and the organization to diffuse the issue and "make it go away" (P7, P20) immediately.

The power and influence of government and politicians were other sources contributing to moral distress for nursing leaders. For example, the morally distressing element frequently identified originated from mandates or opinions regarding the delivery of health care where leaders were directed to take action. As one participant shared,

> I've experienced moral distress when we get an order to implement a plan from a Deputy or Ministerial government level with no clinical input or critical clinical planning behind it. It is usually a political reaction more than what is considered best practice. There are two waves of moral distress. For me trying to advocate what is best for clinical practice and then my leader advocating from a more political perspective. In these situations, we are both feeling the turmoil. (P31)

Another participant shared,

> We have politicians who go out and make statements about care expectations. Since 2007 I have been working on trying to effectively move ambulances from ED hallways and getting those patients into beds and in-front of doctors. What is not clearly understood by the politicians is it's not the ED who doesn't have the space, we need more inpatient capacity. Financially, it is cheaper to keep the patients in the hallways in ED than to regularize new hospital beds, which is clear to me because I have been in the system so long. (P21)

Although it was recognized in this study's interviews that politicians and government actions create moral distress for some nursing leaders, there was also a general perception that government leaders, themselves, may experience moral distress while navigating health care

issues within their roles. Concern was expressed about the level of education and expertise that ministry leaders bring to their role.

> I know that when you take a look even at the people in Health Minister positions how many of them have any kind of a real current clinical background. We just don't have the expertise needed to figure out our complex system and guide us to sustainable solutions. Politicians are looking at making as few mistakes as possible so they can be re-elected. Primary and community care isn't going to cure the entire system. We need to build capacity both within and outside our system concurrently. (P22)

Finally, several participants commented on national or global issues such as economic recession or significant public health concerns like severe acute respiratory syndrome (SARS) or Ebola, which had created moral distress among nursing leaders within the health care environment. One example highlighted by participants in the Prairie Provinces was the recent oil and gas industry recession, which triggered an increased need for mental health and addiction resources and created capacity issues within the health care system. In addition, participants shared poignant experiences of moral distress when they were tasked to prepare and care for patients who were exposed to SARS and Ebola. The morally distressing elements of these experiences related to insufficient resources (human, capacity, and equipment), a lack of access to timely global knowledge and policy, unmanageable workloads, insufficient education, and a lack of attention to advocating and ensuring employee protection/safety and organizational/provincial/federal support.

Internalized constraints prompting moral distress. While the above chapter's section discussed external issues that prompted moral distress, this next section focuses on the sources of internalized constraint, or those constraints held by or within an individual. Internal constraints refer to personal characteristics which, when triggered, can create distress and have consequences for an individual's values, integrity, or very well-being. From the perspective of participants, emotions and feelings impact the context of the moral distress experience.

Participants identified four sources of internal constraint as common in their experiences: fear, powerlessness to act, silenced voice, and isolation.

*Fear***.** One of the common internal constraints prompting or escalating moral distress was fear. This interpretation was distilled from groupings and patterns found in the explanations of the experiences of moral distress through comments such as "It's a dangerous world we live in" (P5); "She had to talk me off the cliff" (P1); "It's a pressure cooker" (P19); and "Walk on coals while keeping a clear head" (P20). These statements convey the intensity of the experience, emotion, and understanding of their experience of moral distress. Specific types of fears included job loss, failure, and inadequate negotiation, as well as the inability to determine ethical solutions, resolve conflict, and manage/navigate inappropriate and abusive behaviors within the leadership culture.

Loss of job was one of the most frequent and prevalent sources of fear. One participant's first fear was entering an excluded position (a position not represented by a bargaining agent) as a leader. Unlike unionized staff, participants acknowledged the lack of a safety net to fall on when or if one makes a mistake within the political environment of health care. Job security becomes more nebulous with career laddering while the importance of social relationships and perceived performance within the political culture become paramount.

Fear of failure was another concern echoed by many participants. One participant contextualized this fear of failure from three lenses: social, financial, and moral:

> No one wants to fail. Anyone in leadership is usually a high achiever so to fail, well for many, that isn't an option. What I really believe is people can't afford to live by their values and when I say they can't afford it, financially they can't afford it. If you were to live by your values, which we all try to guide ourselves every day by, we probably wouldn't have a job. If I stood up for everything that really is totally against the values that I hold as a nurse leader I probably wouldn't be working so that's my moral distress, that my values have to be compromised all the time. I wouldn't want to see patients in the hallway. I don't condone some of the practices because of the congestion but I'm

> trying to work within the system to try to do the best job I can but I find it is really in direct collision with my own personal values. (P7)

Another internal feature that influenced participants' moral distress was the inability to adequately negotiate for resources. The implications of not being heard or successfully acquiring resources for patient care was noted to have ripple effects to the delivery of safe and timely care to patients as well as a reflection on effective leadership skill. One participant shared that there is an undertone held by staff, you are not doing a good job as a manager if you can't get the resources and another held by senior leadership that if you do not have control over your teams, there "is something wrong with your unit or the staff is not happy" (P12). Another participant shared her perception of the influence of relationship on negotiations within organizations. She stated,

> Even though we are all in the same program, at times people lobby competitively for resources for their site. That I found quite distressing as I wasn't able to lobby maybe as strongly for certain things for my site as they were or maybe they had backing of higher up leaders for certain things that I didn't have, or whatever reason. (P9)

One participant further reflected on negotiations with health care unions. On reflecting on her role as a nursing leader, one participant shared that several of the morally distressing situations she has experienced had involved the union. She stated, "I believe we have become held hostage by the union. You have to be able to stand up to the unions and tell them what you are going to do as an employer because I'm actually responsible for the patient care. . . . The unions cause me moral distress because then staff start threatening you with I'm going to call the union in" (P7). The concern this leader had was ultimately patient safety and, more importantly, how vulnerable leaders can be if there is no mentorship in the art of negotiation and lobbying to keep the patient in focus.

Another fear expressed was being unable to find a solution regarding a complex operational issue or difficult clinical ethical situation in a timely manner. The underlying moral element shared was the fear of not knowing what to do and knowing you have to make a decision. As one participant stated, “When you start you aren’t given a manual on how to solve all those unique situations that occur; you have to learn through trial and error” (P13).

A number of the nursing leaders emphasized the responsibility and accountability for resolving conflict within the clinical and organizational environment. These conflicts ranged from simple resource issues to multifaceted ethical clinical situations requiring complex decision-making. From the stories shared, navigating reconciliation in complex ethical patient-centered situations (e.g., end of life dilemmas, resource constraints, global health threats, etc.) was and could be extremely difficult and challenging. Specifically, participants shared their fear of making the wrong decision during complex ethical situations that could impact and potentially harm the patient, employee, organization or greater society. One participant shared an experience from years ago when the organization was eliminating positions. The participant knew there were not enough leadership positions for all applicants. She shared how difficult the decision was as she knew going into the interview whom she would be selecting, based on the senior leadership feedback, which made the situation very difficult as she knew whom would not have a job at the end of the process. For her, this experience was a distressing situation from a personal and professional lens.

Several participants also reflected on their feelings of moral distress during experiences with global health threats like SARS and Ebola. One participant shared the weight of her decision-making leadership experience through the 2003 outbreak of SARS in Canada, stating “There was no direction from the hospital, World Health Organization, or the Ministry of Health,

so it was only a few of us clinicians who were flying by the seat of our pants. It was scary. There were a lot of difficult moral questions we tackled to get prepared" (P27).

In the context of resolving conflict and the underlying fear of doing harm, one of the ways that several leaders shared in helping them make some of these difficult decisions was focusing on the greater good. One participant summarized this focus:

> What I've come to realize and accept is sometimes making patient-centered decisions, with all those other pressures, does not always mean a decision that is best for an individual patient at an individual time given what their needs and desires are. Sometimes making patient decisions is about looking at the broader population and making decisions that will have a positive impact on a larger group over time. I guess I've been able to find a way that I can actually do that, sometimes its situation by situation, sometimes it's a broader population situation but I've been able to do that by listening to my own instinct and internal antenna around whether or not those values are being compromised. (P16)

Fear of incivility and violence in the workplace, which are serious issues within nursing (American Nursing Association, 2016), was referenced by participants. According to the participants, these behaviors are also present within the leadership culture in health care. All of these inappropriate behaviors have an impact on workplace environments and the individual, causing low morale and job dissatisfaction. Several stories were shared where participants' fear augmented moral distress. In short, participants' fear or worries dictated their action or inaction in their decision- making with complex situations involving the threat of violence:

> I was in a meeting with several colleagues and a senior director who started to scream at me saying 'You group of people.' She was screaming and poking, poking, poking me physically as she lost it. I was amazed at how violent her behavior was, it didn't bruise me in any way but I felt the violence of it inherent in the assumptions and the tone. I was amazed by that and I thought wow, that's so wrong. When I later went back to talk to her with somebody else in the room I discovered that she was completely distressed and she herself was losing it. I could be the victim but it was bigger than that. (P5)

Another compelling story is shared:

> I was standing at the bus stop at 7:15 and the phone rang, and it was the executive director on the phone. I answered, and she was literally screaming at me going how we

> (my unit) give a patient an infectious organism that caused his death. I'm standing at the bus stop being accused of causing the death, supporting poor nursing practices, and leading an environment that caused harm to a patient. As I talk about this I still feel sick about this. I shouldn't have been treated that way. After that, I dreaded interacting with her. (P20)

In both of these reflections, the leaders discussed the impact of the inappropriate professional behavior, incivility, and violence on themselves and the organizations.

Powerlessness to act. While participants predominantly felt empowered and confident in their professional lives, due to the complex work environments, leaders acknowledged there were periods when they felt constrained and unable to act on their judgment and perceived themselves to be powerless to challenge the system. The construct of moral distress rests on the notion that there is conflict between what nurses know to be the right thing to do and some form of constraint. A particularly vital element as participants navigated the ethical whirlwind to guard against the feeling of powerlessness was their ability to build and rely on their own moral leadership competency. Many of them talked about the need to have a knowledge of bioethics and a strong moral compass for their decision-making in order to guide them out of the whirlwind. Moral leadership was believed to be nurtured through experience with ethical issues, mentorship, and formal education. One leader shared the angst and distress he experienced when, as a new manager, he was trying to figure out how to manage organizational pressures to control overtime when balancing known professional needs of care on one of his units. A peer mentor offered sage advice stating, "I've been a manager for 25 years. My overtime has skyrocketed every year and I'm still here, so stop worrying" (P2). These words calmed him but, more importantly, put things in perspective.

Multiple stories of complex ethical clinical situations in which participants felt disempowered and experienced a loss of power or control over situations were shared. Situations included medical futility (interventions that are unlikely to benefit the patient), end-of- life decisions, complex medical or social discharge planning, in-patient capacity issues, organizational process, new initiatives, human resources, and availability of community resources. Powerlessness was also expressed in situations when they either disagreed with their supervisors or felt as if they were not being heard or perceived to be supported. Examples included being told to implement a project or initiative when the leader understood that it wouldn't be successful due to multiple reasons such as staffing, morale, or front-line leadership availability. One participant shared an experience where insufficient staff resources were compromising patient care and patient flow. The tension on the unit and with the union was escalating. When the nurse leaders brought the issue to her supervisor for help, she was dismissed, resulting in a negative impact to her relationship with the staff. The participant reflected,

> I had no power. I'll work within the system, so having no power in fixing this situation was very morally upsetting. I had to tow the party line on a boat that I didn't want to be on. I agreed with the staff and saw the impact. That's one of the most challenging things in leadership- when you disagree with the senior leadership team in the direction they want to go and you disagree strongly with it but then have to abide by it. (P2)

These examples can be interpreted as leaders feeling ineffective as patient advocates, given they are not able to support and instigate change within their organization. Furthermore, several participants expressed frustration, anger and, at times, apathy when they felt disempowered (over influencing or supporting care situations), especially when there was a strong political mandate attached. The participants' perceptions of powerlessness exacerbated the negative feelings associated with moral distress. "Some battles are not worth fighting" said

one, “whether it challenges you or not, it’s not worth fighting because what are you not going to gain from it” (P3). Another stated,

> I don’t know if it’s the expertise or the unwillingness of people to speak up and put themselves out there for fear of what it might do to their career or for fear of retribution. I’ve seen that in my past where you’re just going to roll with it and sometimes you just have to say you know what, I know I’m going to be really unpopular but this is the challenge, this is the issue and I know you don’t what to hear about it. Some people you know just want to continue to be promoted, continue to be looked at as the good guy. You don’t want to be pegged as uncooperative or not willing to change so you have to be careful. There is that saying, ‘You’ve got to pick the hill you’re going to die on.’ (P22)

Silenced voice. Findings from this study suggest nursing leaders have encountered challenges in relation to their supervisors having silenced their voice regarding issues or concerns in the health care environment or system. All but one participant acknowledged that throughout their tenure as a nursing leader the participants have felt silenced by senior organizational leaders. The feeling and action of being shut down occurred in both public and private interactions through verbal and non-verbal behaviors. One participant shared her reflection on an interaction during a recent leadership meeting with her colleagues and senior leaders.

> The tension was so high in the meeting and the body language was louder than words. There was lots of eye contact between some and none between others and the non-verbal language was louder than the verbal. I got pulled aside by my Director afterward who said, you’re giving the impression that we don’t have this under control and I need you not to do that. Do you understand me? I didn’t realize that I was giving off an impression, but I guess I did. (P27)

Participants expressed a variety of perceptions on the impact of having one’s voice silenced within the organization. One of the prominent impacts acknowledged was on the individual. Leaders disclosed that being silenced impacted their confidence level and their feeling of being heard and appreciated. Some leaders noted it created disappointment and hampered their relationships with their supervisors. For example, “I lost respect right away for

that person and I knew exactly where I stood with her. I don't trust her or feel like she's got my back and I'd do anything to switch directors" (P12). Another leader shared how being silenced as a new leader increased her self-doubt, especially when she already felt like an imposter, unsure of herself as a leader. She remembered thinking, "This is too big for me. I can't do this. Who do I think I am?" (P11). In contrast, another leader shared her appreciation of being shut down by her director with whom she has worked for over a decade. When her supervisor did this to her when she first began as a manager, it created a tremendous amount of distress that impacted her confidence. Over the years she learned from feedback and through becoming more politically astute that she has interpreted this action by her supervisor as a way of communicating to her that "she has it and that I may be stepping on a landmine" (P17), inferring that greater moral distress could occur if her supervisor had not intervened. She stated that while this wouldn't work with other leaders, her trust and relationship with her supervisor has allowed her to be silenced when she is missing something that politically could harm her career.

Participants also shared the impact on the organization of being silenced. One participant shared, "There certainly can be moral distress if the dialogue is shut down because it can be perceived as violence when it might not have been intended as violence" (P20). Several mentioned a negative ripple effect on an organization's culture. The morally distressing elements spoke to an underlying tone of oppression, violence, and personal risk when leaders are silenced. The silence ,in turn, creates a culture that silences:

> When directors feel shut down, they will then turn around and it's that whole hierarchy of violence or pressure, you shut me down, I shut her down, she shuts the girl down behind her and we start that culture. If the dialogue is shut down it can be perceived as violence when it might not have been intended as violence. When I follow up with my supervisor who yelled at me, she spoke about being so stressed that she felt like her head was going to explode. It allowed us to come around and have some humanity but I think she never liked that I called her on her behavior so there was always a residue. You have to be

> willing to put a lot on the line to call out to that behavior but I think the reason we don't do it contributes largely to moral distress. (P5)

Isolation. A number of the participants reported feelings of isolation in their experiences of moral distress. Participants found the job very lonely and believed leaders' work was inherently isolating. One described it as being "very much an island" where often they are navigating these situations alone. This could occur from not having a referent group easily available nor support from HR resources, coupled with a lack of support from their supervisor and being new to the organization. As one leader reflected,

> I tried to go to HR but I realize that because I was new at this site I didn't have that relationship with them and the HR person assigned to me had a strong relationship with the other leader who was involved in this ethical situation. I realized that I had to be very careful with what and how I said things so I isolated myself at the site level specifically because the other manager had been there for a long time. (P3)

Another participant pondered on this internal constraint by saying, "I think, unfortunately, sometimes we think that is part of being a good leader" (P22). Thus, a perception was held by some that internalizing their experience reflected good leadership practice. When nursing leaders did not feel supported by individuals in leadership positions, they described a sense of frustration and helplessness. The failure of receiving supervisory and organizational support for the nursing leaders' concerns resulted in participants seeking outside resources such as family, colleagues, or regulatory guidance for support.

Summary of leaders suffer, too. Nursing leaders clearly suffer from moral distress and may, in fact, suffer more due to the expectations of their professional role. These expectations held both internally (by the leader) and externally (by the organization, employees, and profession) carry significant weight. The leader is expected to be all-knowing and on top of all things, not to be vulnerable and definitely not to show emotion. These elements add to the

complexity of the situation and may make it harder for leaders to navigate moral distress. These may also contribute to an increased intensity of negative feelings associated with moral distress.

While it was generally understood that moral distress was more prevalent at the middle manager level, every level of leadership was identified as susceptible to moral distress. The similarity shared at all levels was a desire to successfully perform ethical professional responsibilities as a leader despite the morally difficult situation and moral distress experienced.

Participants emphasized that moral distress is multi-faceted, intermittent, situational, and ubiquitous. Leaders must not only deal with patient ethical issues but also the ripple impact of the situation, one that can extend from the patient to the individual (leader), employees, organization, and larger community. Participants emphasized several common external and internal sources of constraint that triggered moral distress. The participants' perspectives on these constraints were powerful and provided new insight into the current constraints present in the health care system. The morally difficult elements of these sources of constraint were revealing. The outcome of this in-depth analytic exploration of moral distress revealed a leadership perspective, providing a broader depth in understanding of the phenomenon.

Relationships Matter

The second overarching pattern is that relationships matter, but they matter differently. Participants emphasized they sought out connection, either formally or informally, with peers, supervisors, family/friends, or other professional relationships. The types of relationships that are relied on most by nursing leaders are outlined in Table 4.4 and illustrate the variety of relationships needed to support nursing leaders in alleviating moral distress. Participants also emphasized that these relationships during periods of moral distress were critical to their healing, stress reduction, personal growth, and overall quality of life. Furthermore, depending on the

nature of that relationship, specifically with supervisors and colleagues, the experience was either positive or negative in terms of navigating moral distress.

Table 4.4

Sources of Relational Support

	Nursing Profession	Other
Professional (formal) Relationship	Supervisor	Allied Health Peer Physicians Professional Networks Followers (Employees)
Personal (informal) Relationship	Peer	Family/Friend Self

Perhaps it is so obvious that it is almost overlooked, but relationships matter when it comes to problem-solving and resolving moral distress. Participants emphasized the benefits of utilizing support systems to discuss the conflict, assess the organizational risk, obtain collateral information and knowledge, and gain assistance in decision-making and guidance in taking next steps for resolution. This ultimately prevented the isolation discussed earlier in this chapter that furthers the suffering of moral distress. Given the isolation, participants understood the importance of developing and relying on solid relationships and coalitions to navigate moral distress. A variety of organizational and professional constraints restricting relationships were frequently identified by participants including confidentiality (professionally or organizationally), politics, availability, contextual understanding of the situation, and trust. Consequently, the importance of relationship and the very role of being a leader—may account for the proverbial lonely at the top syndrome—and may be responsible for the prevalence found within these participants, suggesting that navigating through moral distress as a leader may be more difficult.

This section reviews the primary relationships identified by participants. Of all types of relationships discussed (supervisory, nurse-physician, nursing colleague/peer, family/friend, and self), it was the supervisory relationship that was most integral to the outcome or resolution of moral distress, and it was the nursing colleague/peer relationship that provided significant support for the leader during and after the experience. To better understand the importance of these relationships and its influence on moral distress within nursing leaders, this next section describes the essential relationships that support nurse leaders during times of moral distress.

The importance of one's supervisor. It was apparent throughout this research that having a positive relationship with one's supervisor enabled participants to make sense of and understand situations that created moral distress. The majority of participants openly acknowledged a positive relationship with their supervisors. Characteristics of supervisors that contributed to positive relationships included approachability (open-door policy), visibility (in the clinical environment), mentorship, trust, confidence, engagement in the clinical day-to-day work, and collaboration/partnerships among all levels of leadership. These characteristics were valued by nursing leaders as it helped them make sense of the ethical experience, offered much needed support, and provided a feeling of relief. One participant poignantly reflected on her supervisor's support, "I'm lucky to have the boss I have in that she has talked me off the cliff too many times to count and been my sounding board. I've also talked her off [her cliff], which is a privilege as I know and believe this means we have a solid relationship" (P1).

Participants further elaborated on what aspects of dialogue with their supervisors they found supportive as they were working through the experience of moral distress. These included support (emotionally, physically, politically), guidance (what would they do), active listening, patience as well as being helpful when difficult situations were shared by offering sympathy,

expressing confidence in the leader's ability, and offering mentorship (advice) and coaching (collaborating with the individual to design action plans that will help them move the situation forward).

> I can go to her and she's not going to say "What the hell are you thinking? Are you stupid or something?" She knows when to give support and knows when to let you make mistakes. She just has that sense without being domineering. It's very comfortable; she's not intimidating. I think she knows how to manage a leadership team and how to get the most out of people without making them feel bad or putting them down. If you made a mistake she's like that is ok, you might want to try X, Y, and Z the next time. (P27)

This captures not only the support of the supervisor but the mentorship/coaching that was present in this participant's relationship. Multiple participants discussed the importance and value of mentorship/coaching during times of moral distress, although they acknowledged that mentor/coach relationships and orientation for nursing leaders across their organizations was limited or non-existent.

> We do a good job with our front-line nurses in mentorship and orientation but we fail to remember new leaders need this too and fall into the same novice to expert continuum as front-line nurses. Seasoned leaders know the importance of creating networks and the value of mentorship. It's the novice leader I worry about who really needs mentorship from their supervisor during tough times. (P8)

Those who identified having a mentor/coach relationship emphasized that these relationships organically developed with their supervisor and "luck" was often associated with the pairing of individuals. That said, not every supervisor-employee had a mentor/coach relationship and as some participants noted, these relationships were found through informal links through the organization with other senior leaders or past supervisors. Several of the participants had at least one or two key mentors to whom they turned to for support and attributed their success in having these individuals help them during periods of moral distress.

The visibility, engagement, and partnership among nursing leaders within all levels of leadership was also indicated as being helpful and supportive during times of moral distress,

specifically if the situation extended beyond the organization to the larger community. One story of an ethical situation that involved allegations of causing harm to a patient received significant national media attention. The interviewee shared how the active engagement, visibility, and partnership of the CEO with the other leaders managing the event significantly helped resolve the moral distress experienced by leaders and front-line staff through acknowledging support of their actions and decision-making.

> Well actually our CEO at the time was a very decent guy and you could approach him and talk with him directly. I met with him several times during a very difficult situation that received a lot of media attention. He wanted to help and we felt that support. He and I met with the staff and leaders. We were in it together including the CEO which helped navigate the situation and turmoil, especially within the organization. (P5)

One of the interesting observations about the importance of supervisors' support was the participants' self-reflection on the support they provide (as leaders) to those to whom they are responsible. While the participants acknowledged how important and beneficial it was to receive support, many shared how challenging it was too maintain visibility, engagement, and approachability for those they lead. In fact, one participant shared her feelings of frequent moral distress when she was not able to support her managers the way she was meant to, the way she believed she needed to. The undertone of this reflection is linked to span of control and the moral incongruity in not being able to meet the expectations of one's responsibilities.

> I had a group of managers where some were more experienced, and some were new. I just always felt challenged or behind the eight-ball when it came to being there, being visible to them or supportive of them and what I thought they needed. I guess for me that caused me a lot of moral distress, I just didn't feel I was doing a good enough job. I had lots and lots of hot priorities and I tried readjusting. I changed a lot of things in how I approach things to try and be there for them. That was quite distressing when I was pulled in so many different ways and found out one of them was not performing well that was significantly impacting the unit and patient care. (P9)

As noted, the majority of participants felt that they had a positive working relationship with their supervisor. Many reported feeling safe in disclosing their feelings of moral distress.

The strength of the relationship was important, and the level of disclosure varied based on the situation, duration, and moral incongruity. All felt there was a fine line in disclosing too much for fear of being viewed as being unable to cope or negatively impacting one's career. Levels of comfort varied. One noted that she felt completely safe in disclosing her true feelings to her supervisor as she has an "incredibly strong bond and friendship" with her. She went on to say, "She recognizes that I need to vent. She always supports and then she can be the voice of reason or sometimes just step in and make a decision for me when I can't" (P17). Another shared,

> Initially, I felt safe disclosing to her because of my relationship and because of the values that I believed was compromised personally, professionally, and organizationally. Had I had a different or new director where I did not have the relationship I had with her, I would not have felt safe because as we know, in our world, leadership is more an art and it is political. As the situation intensified, I became a bit more guarded due to politics and relationships. (P3)

A few participants expressed concern and fear over the amount of disclosure shared with supervisors.

> When I started to perceive that the director wasn't actively listening to my concerns, especially when I was dealing with moral distress, that changed my relationship with him. I was performing at the same level, meeting targets, but the verbal feedback was starting to change as were my performance reviews. It changed my relationship in the sense that you can't be sharing this information because it's not going to reflect well on you. (P8)

It was evident from the participants' comments that a positive relationship fosters openness, trust, respect, support, and the creation of a safe place to discuss the challenges of ethical issues where complex decision-making often occurs. The supervisor is viewed and plays an important role in helping to resolve the conflict leading to a more positive outcome. In contrast, several specific supervisor behaviors contributed to negative relationships, a loss of respect, and negative outcomes of moral distress. These behaviors included micro-management, lack of transparency, disregard for process, lack of nursing leadership representation, and leadership incompetency.

Micro-management was one of the behaviors emphasized by nursing leaders as being destructive to the employee-supervisor relationship. Participants clearly valued independence and professional autonomy. This behavior was considered oppressive, disrespectful, and demonstrated a lack of trust, all of which contributed to ethically difficult situations and moral distress. One leader reflected,

> For me personally, I like to be independent as a leader so obviously if I have a boss or somebody who is micromanaging me, I find it disrespectful. I like to have the freedom and the respect and the trust to be able to manage as I can manage. After all, I was selected to do the job so let me do the job. You get into some of the meetings and you're asked for input yet there is a hidden higher agenda and it's like ok, come on. If that's the direction the region is going, just state that and then we'll work within that, but don't ask for all my involvement or an opinion if that's not the direction we want to go. (P28)

Participants expressed varying interpretations of the significance of being micromanaged as it pertained to moral distress. Micromanagement was viewed as creating feelings of self-doubt, perceived lack of organizational confidence in the ability to lead in the situation, feelings of being undermined, powerlessness, and creating reactive defensive behaviors. Feelings of anxiety, fear of job loss, and decreased self-confidence all intensified and influenced the situation at hand:

> I had a Chief Nursing Officer that I reported directly to as a manager who was very much a control freak. It got to the point where I couldn't send an e-mail out without her scrutinizing it because she needed to control everything so it became analysis paralysis and I felt that I was unable to do the things that I needed to get done. I really started to second guess myself and question if I should be in the role. This behavior creates a culture of undermining which trickles down through the organization. (P26)

It became apparent that supervisor's micromanagement behavior triggers a reactive defensive nature in nursing leaders potentially generating a lack of transparency and dishonesty. When autonomy in practice is restricted and constrained, there is the potential of organizational vulnerability:

> I would say for me there's manipulation and hiding of some operational things, so you become clever as a manager in what you share with your boss and what you don't share, what you manipulate or are you completely 100% honest with your boss. I hate to say that but the system or sometimes the boss is such that in order to support your staff you've got to do some of that stuff. It feels wrong. Am I outright lying? There is probably some untruth to some of the things, but at the end of the day am I getting what I need for the staff and the patients, yes! (P2)

Behaviours contributing to negative relationships between supervisors and nursing leaders involved lack of transparency and disregard for organizational process and ethical practice. Many participants, reflecting on their experience of organizational re-structuring, acknowledged these behaviors. From participants' perspectives, these behaviors created significant strife and conflict among personal, professional, and perceived organizational values. One participant shared a morally distressing experience during reorganization where a senior leader approached her many weeks before the job application process required of all leaders:

> My boss, who's worked with me for many years, approached me and said ok, this is very confidential. These are some options for you. You take either this or your name goes into the pool with the other managers to express interest. In that moment I had to make a decision that I'm not even able to think through before answering so I made a decision and then I go away and I think a bit more about trying to make sense of it. I'm told it's just change, you've got to go with it, and it's good. What about my colleagues, who are not getting the same offer I am? Right now we are in limbo, fearful of discussing anything and I feel I've kind of been shut down. People are losing their jobs or not getting what they want so you'd better just go with it. It hasn't been a fair, transparent, or ethical process. (P10)

Multiple participant narrations about organizational restructuring shared how perceived supervisors' disregard for organizational processes created moral incongruities for many of the participants' personal and professional value systems. Participants shared their observations and perceptions of certain supervisor actions that perpetuated moral distress such as perceived inequality and unfair hiring practices for senior leadership positions; such actions were perceived to be based on relationships versus clinical knowledge, expertise, and merit. As one participant stated, "It's not what you know, it's whom you know, and relationships are very huge and that's

what gets communicated both verbally and non-verbally" (P8). The moral incongruity expressed by participants was a violation of the ethical principle of justice where fairness and equality are core values of professional nursing. The importance of hiring the right individual for leadership positions and the impact on patient care was summarized succinctly by one leader:

> I think we hire people into leadership positions for the wrong reasons; I don't think we have the strongest leaders in roles from the top down. Let's just be honest. Until you get good leaders who are focused on the patients I don't think we'll ever be successful. (P9)

Other participants also reflected on the advancement of leaders based on connections (relationships) these individuals had and/or just hiring the wrong individual for the professional role. One participant explained the moral incongruity she experienced. For her, this incongruity created moral distress as she observed and perceived her supervisor being unable to professionally understand the complexity of the situation, competently lead the situation, and constrained the participant in the required actions needed to ensure safe patient care.

> I do wonder how some people got to their roles. I believe some of the people who have ended up in their positions don't have the front-line experience to understand the staff pressures or question what it is they're actually talking about. If you focus more on the numbers, dollars, and the business of health care and not the patient's story, you'll lose that connection to what is needed to happen to make things better. (P14)

Thus, participants' attempts to make sense of the moral distress associated with organizational change revealed various associations with favoritism, clinical incompetence, and concern for quality patient care. Many also emphasized concern over the far-reaching organizational implications that would impact patient care as a result of hiring the wrong individual for leadership positions.

> I think the ultimate fallout is going to be that good people will leave because of that lack of trust and unethical promotion. It will be harder to recruit good leaders to the organization. What that means is you don't have people who understand how to motivate, engage and reward staff to move towards those right outcomes. You end up with very transactional leaders in the organization so ultimately how this is going to impact patient care is that because of the fallout we are going to have an increasingly staff and

> system-centric response to issues where we replace a lot of things before we consider the patient experience. (P15)

The profession of nursing comprises the largest workforce among health care providers. As such, the majority of participants emphasized the importance of leadership by nurses as these leaders worked under the same regulating professional standards and understood the work of front-line nurses. Several participants discussed the challenges of working with senior leaders who viewed situations through a different professional lens such as project management, finance or other allied fields. One shared she felt her organization was very fortunate in that every senior operating officer except one was a nurse by background so nursing leadership was perceived to be visible at a high level of the organization. She expressed concern that at the higher executive leadership level there was no nursing representation, which she perceived sent a message throughout the organization that the nursing voice would not be heard (P25). These nurse leaders believe that to understand the ethical issues in health care one must know the work involved, not only the work of nurses but also the professional values of nursing. Several participants discussed the far-reaching impact of decisions by leaders who ignored or overlooked core professional values, resulting in moral distress across the organization.

> I've really struggled with one leader's approach because she is not aligned with our nursing values. She is very into building turf and kingdom and that's not how we work. Our people in HR fully understand that our business is about people at the front-line helping people that we're serving and they are very supportive of that, the same with our finance people. When we talk about where the money is being distributed, it's about, ok how is this going to help improve our care to those we serve. They suffer because they actually need more people to do their work but they would rather it go to the front-line so that we do a better job serving people. This person is driving a wedge between that and is making assumptions that non-operational resources are more important than operational resources. It's changing the delivery and support of care and I don't agree with that. (P31)

This participant clearly valued the need for nursing leadership and articulated how she observed a particular non-nursing leader creating a rift between operations and the rest of the organization,

which then impacted how nursing care was delivered. Moral distress was also created when supervisors lacked clinical and/or leadership competency, did not know their role, or did not understand how their actions and decisions influenced others.

> I think they had a boss in place that didn't understand the position, didn't understand their role and responsibilities, and so there was no support or communication. The middle leaders were getting told one thing-they've got all the responsibility but at the same time they've got no power to do it (because the senior leader didn't communicate this). When things went wrong, the managers were the ones that had to answer for it when it should have been the senior leader's responsibility. She didn't know her job. (P22)

This was acknowledged as a contributing factor to fostering a negative relationship with followers and in creating a negative experience of moral distress.

> I think she was a horrible leader. I think she was a very insecure in her role so in her insecurity, which must have been a horrible place to be, she was constantly doing damage control. Her way of doing damage control wasn't to bring the team together. It was to divide and conquer and to ensure that you never felt secure. (P20)

Participants acknowledged that when leaders do not understand the accountability and responsibility of their roles or the impact of their incompetence on followers, then fear, distrust, and moral distress is created within the health care environment.

> Things that are brought forward aren't really going the places where I'm used to seeing them go. The flags that we raised are acknowledged but not moved up which is concerning. In rounds when I would say we have no trauma beds, we cannot feed our patients and there are four ambulances in the back hall, I was told by the director, "We know best. We've acknowledged, that's all we're going to do, we've acknowledged". Wow, I'm supposed to feel ok knowing I have escalated it and it stops dead? It doesn't feel ok. It doesn't go away. I can't just ignore it and hope for rainbows. If I could just walk away and say I've done everything I could, that would be great, but I can't. There is helplessness amongst the upper leadership team to say I don't know what to do next, I hope everything works and hope a better plan comes forward. (P14)

Nurse-physician-administrator relationships. In terms of types of relationships related to moral distress, nurse-physician-administrator relationships were often considered contentious. Historically, physicians and nurses have shared a complicated relationship influenced by gender, social status, and power. A few of the participants acknowledged that physician behavior was a

source of moral distress for nursing leaders, specifically as it related to the influence they bring, the provision of health care services, and in a perception of misdirected care. While other industries experience power and influence conflicts among professionals, within health care long-standing traditional power imbalances continue to affect ethical situations and moral distress.

> You don't see it so much anymore with regards to the up and coming physicians, but there is certainly a legacy of physicians who feel that their voice should be heard more than other areas in health care, and unless you have coalitions, partnerships or well-developed relationships, it is very difficult to get things done without physician leadership taking things forward for you within the health care setting. That is a very real constraint. (P25)

Another source of moral distress triggered by physician behavior was in the provision of service to patients. One participant shared a poignant example when a physician shifted the responsibility of service (to a consulting physician) for a specific patient population based on financial gain versus best patient care. "This physician made an autocratic decision based on his own potential financial gain versus what was safest for our patients. It had been a frequent practice and one of the biggest areas of contention that I am working on right now" (P11).

Another physician behavior that triggered moral distress was physician-physician or physician-employee/leader communication and conflict. Several participants shared critical incidents or adverse patient events where the root cause of the event was due to lack of or miscommunication and interpersonal conflict that directly (adversely) impacted patient care and triggered moral distress within the environment/organization, among employees and leaders. Finally, one last example of physician behavior contributing to moral distress from a macro-level within the health care system involved employee absenteeism. Multiple examples of moral distress were disclosed involving physician support of questionable employee illness with physician absence of illness letters. As one participant stated, "Sick notes are a joke. You can

get one for a bruise or hang-nail. Unfortunately, some employees know this and try and capitalize on it. The physician usually doesn't even know the person or, quite frankly, care" (P22). Another stated,

> I've seen several cases where the employee is directing care to the point of telling the physician what to write on their sick notes. I have observed this so many times. There is no follow-up, and employees can go to any walk-in clinic and get a note. There needs to be better accountability for physicians who practice this way. (P10)

Participants articulated the need to mitigate these triggers of moral distress which included: continued organizational and professional education on relationship building between physicians and leaders/nurses; implementation of a systemic physician quality process (checks and balance) to ensure that physician provision of patient service is a priority and not influenced (delayed, withheld, or impacted) by financial remuneration; enhanced communication and conflict management education for physicians; and, greater scrutiny and accountability employed in the provision illness absence letters.

Peer and other relationships. While supervisor relationships appeared to have the most dominant impact on moral distress, for better or worse, peer relationships were also significant. One participant who felt she had never been morally constrained by her professional values as a leader attributed this to "Being blessed to have wonderful people working with me. I never felt like I was the only one holding that situation where I felt my role was constrained because I have had such good people working with me" (P6). When it came to peers, participants identified certain types of relational conversations as most significant and valuable. These included sharing knowledge for experience, reassurance, role playing, coaching, openness, and dialogue around the difficulty of the situation. Trust was a strong sub-theme expressed by participants due to the political nuances in the environment. One participant stated, "At times, it's a dangerous world we are always navigating so you have to find allies" (P5). Another emphasized

the importance of being able to vent with a trusted colleague, sharing the benefit of having two "best friends" on the executive team so "We can commiserate together about what is going on." She pointed out "I just can't complain all the time. I need to figure out how to turn it around. You need to be able to give yourself permission to have the pity party but then you need to fix it, otherwise you're just part of the problem" (P 25).

Participants expressed that they also sought out those colleagues whom they trusted, observed qualities that mirrored their practice, sought those who would challenge their thoughts while not creating vulnerability, and those who conveyed a sense of "I've got your back" or safety. While some were specific in expressing value in colleagues who were nurses, others looked to peers with similar responsibilities. As one stated, "I love my nursing peer colleagues, managers, but I like getting to know managers of completely different professional departments as there are similarities but small differences that I learn from that adds to my leadership competency" (P2). Regardless of the professional peer background, participants conveyed that these relationships bring mentorship, friendship, and experiential knowledge. One participant shared, "I learned I have some great friends and that I'm not alone when these experiences occur. Through relationship I have learned peers have also experienced similar or often worse experiences they can share with you, which helps you navigate the situation you are in" (P20). Another participant reflected on the far-reaching implications of peer relationships and the link to communication:

> Change management, project management, finances, developing coalitions, it's all about relationships. If you are able to connect with people on a personal and professional level it is much easier to have those difficult conversations. People become approachable, whereas if they are always on the defense because you haven't got that relationship, it is very difficult to have hard conversations. I really try to connect and make casual conversations to learn more about the person and to develop trust. This has helped a lot in my leadership. I didn't probe but they shared whatever they wanted to share and that helped to build trust and friendship. (P19)

All participants expressed the value of peer relationships. One shared that after a very political situation where senior leaders were noticeably unhappy with the participant's perceived performance, it was colleagues that gave her the needed support required.

> They reached out to me immediately and knew that things were not going well. I hid my last three months a lot, that kind of just do your work and smile and when someone says how are you, good. You can only do that for so long but I had a lot of good friends at work, some managers and directors (not mine) who were wonderful. The thing about friends who are not healthcare people, they don't understand the pressures in healthcare leadership; they just have a real tough time understanding some of the struggles you might be going through and that tension. Colleagues get it. (P18)

Participants who had been leaders for a long time stressed the importance of forming multiple strong peer relationships quickly, in any way possible, when one enters a new organization or advances into a formal leadership role. As one noted, "Sometimes colleagues know the situation and can even add collateral information organizationally that I didn't know" (P 8). One participant, who was relatively new to her role as a nursing leader, acknowledged the need for a shift in collegial support.

> One of the things I found in this leadership role is a lot of your relationships can change when you move into a manager's role. Many of my colleagues that I may have hung out with before are not my support system anymore because I am now the boss. So I needed a new support system with other leaders in a similar circumstance where they can support, advise or give me some honest feedback. (P11)

There were two further peer relationships participants acknowledged. The first was the importance of professional networks organizationally, provincially and nationally to discuss leader focused issues. For example,

> This conference I went to in Halifax where leaders like me from across the country had the chance to sit down and talk to one another about clinical topics of relevance was so valuable. I think sometimes you feel like you are in this by yourself, only you are experiencing this terrible phenomena and then when you actually have an opportunity to talk to somebody you find out that no you're not, there are many more. Just talking to them and sharing some of the things they've done and you've done maybe makes you

> feel a little bit stronger. That you were on the right track and you were doing the right thing. Also, it provides opportunities where you could learn. (P21)

The value found in these professional networks included belonging to a community of practice in which peers could support and work together on key issues that could help one mitigate and navigate through situations that involved ethics and moral distress. For those in more senior roles, these forums assisted in leveraging and partnering on new health care policy and in advancing clinical practice, thus preventing or resolving patient adverse events. The second more formal relationship was the presence of a Chief Nursing Advisor/Nursing Policy Secretariat within provincial governments. This nursing leadership role was viewed as important as this individual works with nursing and allied health constituents including, but not limited to, colleges, unions, associations, and health authorities to ensure nursing and clinical practice perspectives are considered in ministry government policies. As one participant shared,

> This is a very important resource for senior nursing leaders at the ministry level. This nursing role provides great support and is a wonderful link for nursing leaders across the province, especially with all the ethical issues and moral distress that occur when caring for patients. (P32)

Family and friend relationships. Another dominant relationship in navigating ethical issues and moral distress was the support of family and friends. The importance of having a family member (which was usually a spouse) with whom leaders could discuss the situation and share the accompanying emotions created a way to cope with the moral distress, interpret and make sense of their experience, provide a venue for coaching, and offer an alternative perspective.

> I think it's the sharing with others and sometimes, not giving any particular patient information, but sharing with somebody who is not in health care, my husband or even one of my daughters or saying this is what's going on for me. They are kind of able to look at it in a whole different way, why are you getting upset about that. That has been helpful to me too, just having another perspective, because sometimes I can spin myself

> into a tizzy I didn't need to, so I talk with somebody that I trust outside the work environment. (P6)

Participants appreciated the unbiased, honest and confidential ear that family and close friends could provide. This speaks to the level of trust and shared values present in these relationships. Participants found it helpful when family provided support or encouragement by pointing the way forward in a manner that made sense to the participant. They spoke of the value of confidence and coaching that family can provide regarding the individual's ability to work a way through the morally distressing experience. One reflected on how family support can assist nursing leaders to link back to their value systems and help leaders emerge from moral distress:

> My husband and I often talk about ethics and the environment and what trumps some of these mandates and when do you say no and when do you move forward. I have a partner who is really interested in ethics and we talk about that almost daily. He helps remind me of what my ethical framework is which is very important to me. (P5)

All participants felt they had a strong family support system in place. One of the interesting reflections heard several times was how family was an extension of self-care and an important health care boundary that they needed within their role. Family was also reported to give participants a reality check on perspectives that helped participants normalize the situation as they worked their way through it.

> I think a lot of the support that I've had from my family is where they have said you need to be elsewhere. You need those who care enough about you when you can't see what you're doing to yourself but they tell you to step away and you either need to look for a different job or stop worrying so much. That's been my saving grace really, family caring enough to tell me to pull away. (P14)

Humor, active listening, and promoting a healthy work-life balance were some of the strategies families utilized during discussions with participants. One participant shared the appreciation of having someone at home who was offering reassurance and saying, "No, this won't kill you, you'll be alright. Let's open a bottle of wine" (P17). Another leader stated,

> Luckily I have a really understanding husband who listens and he also knows when to tell me enough, put it away or does it really matter. Let's just go out and enjoy ourselves. So I have been able to balance it like that so I'm lucky there. (P7)

One of the interesting reflections shared by a few of the leaders was the concern they expressed for those leaders who did not have strong family supports. For example:

> I also am fortunate and I know that everybody isn't in the same boat. I have a very supportive husband who's very rational and a great sounding board who looks at things very different from me. I would hope that most managers who have hung in there in very challenging portfolios, jobs, whatever, have someone, partner or confidant or whoever, whatever you want to call it, to help them as a sounding board. (P1)

Thus, appreciation of family and how vital this relationship was to making sense of moral distress was significant to a number of participants. They expressed concern for those who did not have this relationship and reflected on the value of close friends outside of the organization/health care from whom they could garner support.

Relationship with self. Another relationship emphasized as being very important in dealing with moral distress was self-relationship, or knowing oneself. Having a strong understanding of one's personal identity was an important relationship to build and nurture as a leader. Participants shared how they found strength and resilience through knowing and understanding who they were as individuals during difficult ethical situations. Many mentioned they believed this was their key to successfully navigating moral distress and viewed it as a leadership competency. Having a strong foundation of understanding and sense of who they are as a person naturally flowed into who they were as a nurse and leader. As one leader reflected, "You need a solid foundation of who you are and what you believe in. It's a solid identification of who you are outside of the organization. As a leader, outside of work, you need to know who you are, what triggers you, and what you do or how you react when you're triggered" (P1). Another shared an experience where she felt conflict in trying to separate work and home life,

which was promoted by her organization, until she realized she held an integrated work/life philosophy. For her, the value of knowing who she was translated into how she managed her work:

> It's been very valuable solidifying who you are and what you're bringing and it's also really helped me think about my work and other aspects of my life. I have an integrated work-life philosophy. Work is very much a part of my life and I'm not going to try and separate that out. I think that's false and I don't think it works for me so I would like to have it all integrated so I'm really solidifying that. I love what I do so I would like to make the most of my professional time that I do have and enjoy it and stay healthy and vibrant and keep learning at work. I feel that will just enhance my life, all aspects of my life. That piece is valuable at this point. (P11)

Participants also discussed the importance of values and how they reinforced personal identity and helped influence moral outcomes and decisions during moral distress. Many referenced their personal ethical framework when they encountered morally difficult situations and how this linked back to their personal and professional values, which were important to them as they helped to create understanding of the moral distress and ethical situation.

> My ethical framework really goes back to my values. I'm always thinking about what are my values, why did I get into nursing, why did I choose to be here and why do I stay in-spite of difficult situations. Why don't I just go take another job? It's really around my values which are about being in community and trying to promote health and well-being. My values are about the learning environment. It's about working, I have a work ethic. Those values are driven by the very things you hear about caring, community, it has to be meaningful, valuable, inspiring and connecting. (P5)

The participant who shared this reflection remarked on how profound her experiences of moral distress were. By reflecting on these situations, the participant connected very deeply with that ethical core and revisited the importance of it. Participants reflected deeply on the question of values, as evidenced by pauses and silences before responding during interviews. The discussion of what moral distress meant to them often led to discussions about their personal and professional values. Several also shared how they often internalized their struggles of value conflict. For example:

> I was thinking about moral distress and what did that mean to me and I'm thinking moral/morals, where does that come from? I'm assuming it's the things that I value, how I've been brought up, it's my faith, it's my education, and it's all these things that who I am. Then distress, well how did the things in the work environment or the patients or the situations when it conflicts with who I am and causing me distress so that I either have to look to compromise my values or say no, these are my values and I have to stick with this. I have experienced some of that, but those things could eat at me a little bit. I used to internalize things a lot more and I don't think that was healthy for me. I feel that I have been better, that when situations come up I find the people in my life, whether at home or at work that I can talk through/ work through how I'm feeling on certain situations. (P2)

Another participant shared:

> I guess I've learned through myself what I truly believe in and keeping that as my foundation. I really believe that I am here to advocate for patients and their families. I set that as my compass. I try to understand that every situation is a bit different but the bottom line is I have to feel that we gave the best care to that patient, we were respectful, and all of those things that are our nursing values we uphold. (P21)

Participants acknowledged a union between personal and professional values that extended to their leadership role. One shared, "My core values are all aligned and encompass who I am as a professional, as a leader and as a human being. The first is treating everybody with dignity and respect for their worth as a human being on this planet. Demonstrating kindness and compassion whenever I can, and I see that as being my human responsibility and privilege" (P15). The belief that in nursing, professional and personal values are one in the same was a strong theme echoed by participants. Transparency, honesty, truthfulness, and doing the best job you can everyday were considered key characteristics. This meant doing no harm as a leader, which echoed strongly with being a nurse. "Is it done all the time, no, but you don't go to work and say now what can I do to be neglectful or to hurt someone. You don't do things to be vengeful so I think that at the core, a lot of it is the same" (P30).

Finally, one of the interesting findings regarding relationship to self and the values of nursing leaders was that many believed that in today's health care environment, leaders cannot economically or financially afford their values. A senior leader stated the following:

> What I really believe is people can't afford to live by their values and when I say they can't afford it, financially they can't afford it. If you were to live by your values, which we all try to guide ourselves everyday by, we probably wouldn't have a job. If I stood up for everything that really is totally against the values that I hold as a nurse leader, I probably wouldn't be working. That's my moral distress. That my values have to be compromised all the time. I don't want to see patients in the hallway. I don't condone some of the practices because of the congestion but I'm trying to work within the system to try to do the best job I can but I find it really in direct collision with my own personal values. (P7)

Another leader implied this was possibly more evident at high levels of leadership:

> I know of some directors who aren't necessarily struggling with the moral distress because they are more focused on job security. That's how I perceive it. I don't know what causes moral distress for senior leaders because they don't usually share it. They don't seem to wear the moral distress. For the last seven years, I have worn the moral distress because to a degree it has eroded me. I have huge consequences from it. I have psoriasis related to years of stress. I've talked to directors over the years and I don't think they are morally distressed for the same reasons. They talk the patient, we're all here for the patient, and yet I see them more morally distressed in term of the position of job security. (P20)

In addition to professional values and conflict, a number of participants noted the importance of spiritual values as another aspect of relationship to self. In fact, spirituality or having an awareness of one's personal faith values can either support one through moral distress or contribute to moral distress. Many participants felt it was important to have a religious or spiritual foundation to help guide one through ethically difficult decisions.

> Faith is an integral part of who you are and also helps you in your leadership. It really helps calm me and it gives me that, Oh God why are you asking me to do this and what is your meaning and how do I help this family or my staff. (P4)

Another participant shared,

> I've always said that no matter what I'll be ok because I have a spiritual foundation and it's always there, it doesn't go away. I think that sometimes when people don't have that

> I can see they rely on other people so if people are their only support what do you do when people aren't there. I think having a form of faith definitely helped. (P17)

While many turned to their faith to resolve problems during difficult times, a few participants shared how their personal faith values actually contributed to moral distress. One leader shared how she declined an employee's special leave related to an extended family member's miscarriage. The participant's decision was based on both the contract interpretation and also on her spiritual belief regarding miscarriage. The employee grieved this decision, and the leader shared that it took a lot of self-reflection and discussion with colleagues for her to resolve the situation. Another leader shared similar turmoil:

> One of the most morally distressing events for me was one case that involved my faith values. I had one of my staff members who is of my faith. She had been talking to a number of patients about faith and Christ. For me personally it was great. This is what my faith is about. I want to share Christ with people and stuff like that. That's on the personal side. Then there is the work side. We can't be doing that as nurses, we cannot be imposing our faith on others. If somebody asks about it, fine, but we can't be just coming in and sharing and doing that. That was a tough conversation I had to have with this person because she was so passionate about her faith and she was a great nurse too. What made it distressing for me was that I had to tell her she couldn't do it and yet in my heart I wanted to do it. It was like whoa this is powerful. As a leader I struggled with this. [I felt I was] just getting on the boat and towing the party line in a direction opposite of my personal moral compass. I could have said, you know what I'm just going to let her continue to do this. Its right for me, but it was not for others. Staff members were coming to me with their concerns so it had to be dealt with that way. The bottom line is I had to do what was right in view of the organization and profession. (P2)

While holding spiritual and religious values was viewed as important, as the examples shared above, they could both contribute to and assist in the mitigation of moral distress.

Summary of relationships matter. Nursing leaders need a variety of relationships to support them in navigating and alleviating morally distressing situations. Participants emphasized that it was these relationships that were fundamental to their coping, stress reduction, personal growth, and overall quality of life during periods of moral distress. Simply

stated, leaders must be able to connect with people to avoid isolation that furthers the suffering of moral distress and impacts the individual's well-being.

Of the types of relationships discussed by participants, supervisory, nurse-physician, peer, family/friend, and self, it was the supervisory relationship that was most integral to the experience of moral distress, and the peer relationship that provided significant support for the leader during and after the experience. Participants emphasized the importance of a positive relationship with their supervisors, identifying specific characteristics of supervisors and dialogue with them that garnered greater insight into how leaders make sense of the ethical experience and in how supervisors can be supportive during times of moral distress for their employees. Many shared the importance of mentorship/coaching by supervisors during moral distress and noted not every supervisor-employee had a mentor/coach relationship. For some, these relationships were found through informal links with other senior leaders or past supervisors. Participants also identified specific supervisor behaviors that contributed to negative relationships, loss of respect, and negative outcomes of moral distress. These behaviors included micro-management, lack of transparency, disregard for process, lack of nursing leadership representation, and leadership incompetence. Ultimately, the supervisor plays a significant role in alleviating moral distress, which accentuates the value of fostering positive relationships that include openness, trust, respect, support, and the creation of a safe place to discuss the challenges of ethical issues.

Several participants acknowledged that physician behavior was a source of moral distress for nursing leaders. This relationship was mentioned several times and was the only relationship noted in a contentious context. In contrast, peers were emphasized as one of the greatest sources of support for nursing leaders. Participants expressed that they also sought out those colleagues

whom they trusted and observed qualities that mirrored their practice, and would challenge their thoughts while not creating vulnerability. Regardless of the professional peer background, the value of these relationships is mentorship, friendship, and experiential knowledge. Family/friends were other sources of support emphasized as critical for navigating moral distress. These relationships afforded the opportunity to comfortably share emotions, interpret and make meaning of their experience, provide a venue for coaching, and offer an alternative and normalized perspective of the situation.

Finally, participants found strength and resilience through knowing and understanding who they were as individuals, which helped them navigate through and out of moral distress. Participants emphasized that having an understanding of who one is as a person both inside and outside of the organization naturally flowed into who they were as a nurse and leader. The use of personal ethical frameworks during periods of moral distress was emphasized repeatedly in helping to navigate moral distress. One of the interesting findings was how several participants believed that in today's health care environment, leaders cannot economically afford their values due to the perceived political environment. As such, having an ethical framework became all the more important. The importance of spirituality also assisted leaders through ethically difficult situations, although for some, these values contributed to moral distress within their role as a nurse leader.

Navigating and Emerging Through Moral Distress

While the existent literature has fully explored the concept of moral distress from a front-line nurse's lens, less is known about how nursing leaders navigate through and out of moral distress. One of the goals of this study was to learn how nursing leaders navigate moral distress, specifically focusing on what strategies they utilize, the lessons that they have learned

from the experience, and what they recommend to navigate through and out of moral distress. The following discussion will explore the elements identified that were acknowledged as addressing or aiding in navigation and emerging from the morally distressing situation.

Strategies for navigation. Overall, participants expressed that navigating the stormy ethical whirlwind of moral distress involved a clinical judgment that was personal and contextually informed by life/clinical experiences, beliefs, and professional values. Emerging from moral distress was described as an active and passive action that involved multiple strategies. Participants reported varied strategies with Figure 4.6 capturing the most prominent. The following discussion shares reflections on how these strategies assisted nursing leaders in their navigation of moral distress.

Figure 4.6: Strategies utilized by nursing leaders to emerge from moral distress.

Developing and refining self-knowledge. One of the most prominent strategies identified as helpful in navigating morally distressing situations was developing and refining

self- knowledge. Specifically, participants discussed self-awareness, self-realization, and a conscious clarity around personal and professional beliefs, values, and biases. The concepts of self-awareness and self-realization were mentioned by three-quarters of participants as either being critical to their ethical practice or as a valued coping mechanism. These concepts were perceived to be intertwined, as noted by one participant who stated, “To be a leader, you have to have a solid identification of who you are, what are your strengths, weaknesses, and your character” (P11). Having a solid foundation or grounding of who you are, what you believe in, and what you want to accomplish was clearly expressed by participants as being necessary for navigating through moral distress.

Self-awareness and self-realization were perceived to evolve over time with maturation occurring on a personal and professional level with every new experience. With each story of moral distress, participants shared that new learning occurred not only from a clinical or operational perspective, but also from a personal perspective, both enhancing their leadership. As one participant reflected on a situation involving a colleague she stated, “I’ve learned so much from this painful experience, specifically about me-how I react, my resilience and determination. It has changed me, and I know I am a stronger person and leader because of it” (P3). Participants shared that reflecting on one’s personality including strengths, weaknesses, thoughts, beliefs, emotions, and motivation aided in understanding how one responded to situations and also how others responded. Developing and refining self-knowledge was believed to allow one to understand other people’s perceptions of you, your attitude, and responses to others in the moment. This ability to reflect and empathize was viewed as fostering personal and professional self-growth and authenticity as well as enhancing relationships.

Participants also shared that part of their development of self involved staying objective. Many participants shared how difficult this can be as the situations are usually patient-centered and charged with emotion. Regardless, the need for critical objectivity was important. Said one:

> Try not to take the situation personally. As a nursing leader, it is very difficult because professionally we are nurses and feel the same way that front line staff feel, especially when it involves patient care. (P9)

Another individual reflected on the importance of "standing in the power" of one's own knowledge. In one participant's first experiences with moral distress as a nursing leader, she poignantly remembered, "This is way too big for me, I can't do this, and who do I think I am? I was suffering from the imposter syndrome" (P 11). This situation lasted for several weeks before she realized that she was unable to resolve the issue independently; however, she discovered she did have the clinical and professional knowledge to lobby for resources to help her resolve the situation and the turmoil it created for both staff and her. Another example that spoke to the importance of understanding one's knowledge was expressed as "listening to one's professional instincts and go with your gut" (P14). For example, one participant reflected on a situation that occurred on her unit when she was a new leader. She stated, "I felt like I was navigating blindly and only had a hunch that something was not right. I took it to my director and we had a good conversation and decided we would just go with the flow. The next day when I got some more information from perceptions from front-line staff, I realized that it was really wrong" (P12).

For the majority of participants, having conscious clarity around personal and professional beliefs, values, and biases was an important strategy for navigating out of moral distress and being able to "let it go." Several participants reflected that this meant staying

grounded and really understanding and knowing who they are as humans. Finally, one last element of self-knowledge that participants shared as important was confidence.

> You have to be confident in whatever you're doing if you are going to make some impact. If you feel totally un-empowered then you are going to just translate that back to your people. So you have to have a certain level of confidence that what you're doing is effective. With what moral distress is, you just can't get sucked into it because it doesn't help. You have to be confident and positive and lead people through it. (P17)

Critical self-reflection. Reflective practice is part of the professional requirements of nurses. All participants acknowledged they engaged in this practice during morally distressing situations. During self-reflection they focused on how they interacted with colleagues, the clinical situation, and the larger environment in order to explore how they had reacted and to help their decision-making. In addition, participants commented on how self-reflection helped them better understand themselves and build on existing strengths and weaknesses.

> I did a lot of reflection and realized it challenged my integrity and the values I work under as a leader, about honesty, fairness, consistency. It challenged what I stand for. I did a lot of self-reflection in terms of what's my part in this. How does it impact patients and the team? Am I making something big out of something that really doesn't have to be big? It didn't make me change for what I stand for. (P3)

Many participants discussed using the technique of internal monologue, described as self-talk, which provided self-opinions and evaluations of what one is doing or should be doing during the experience. Several participants shared it was during these monologues that they questioned their own professional involvement pertaining to the situations. As one participant stated, "While I was trying to make sense of the situation, I did ask myself, could I have done anything different? Should I be doing anything better? Then thinking and being realistic, I'm doing the best I can with the hours I have" (P10). Another shared,

> I do self-talk where I will say to myself, "You're going to say or do something you'll regret. You're going to be disrespectful. You're going to do something you don't like in others so why would you do it yourself." It is more of a self-talk conversation that I have with myself. (P1)

Another technique to navigate through morally distressing situations that participants shared was seeking feedback from others about their responses and reactions to the situation. One participant commented that she found that feedback helped her process and understand the situation at a finer level as well as how she fit into the situation. She stated,

> I had to do a check in with everybody to make sure that there wasn't a problem because there were times that the project lead was saying things at the Executive table and throwing me under the bus. I would do a check-in with the people I was working with, to get real feedback. Knowing the dynamics at play, I was worried that I was not being helpful with other people. The feedback validated my actions and I was able to move forward. (P17)

Participants reported that they used these techniques for self-reflection frequently and that it aided them not only in processing all elements involved in the morally distressing situation, but it also allowed for perspective and confidence. Participants shared how self-reflection allowed them to gain perspective on the situation and on their reactions to the situation. When one participant was asked how she "shut things off" when in a morally distressing situation, she replied,

> Perspective, confidence that you've done what you can and you continue to do what you can to improve a situation until you get to the point where you can't influence or fix anything anymore. The most important thing is perspective and getting out of it. If you have moral distress in the workplace then you are morally distressed about work. If you can't get out of it at work you're going to take that home. Sometimes you can't shut something like that off so you need to know what you can or can't influence and fix. (P17)

Participants emphasized that self-reflection about one event will often continue after the event and contribute to navigating other experiences of moral distress. Critical self-reflection was viewed by participants as a precursor for learning and more importantly a means to understand and guide individual behavior. As one participant stated, "The one strategy that helped me

through that difficult situation was the self-reflection and growth within myself as a person, my values, and professionalism which enhanced my compassion for nursing" (P21).

Tactical process management. It was apparent throughout this research that nurse leaders valued tactical processes to aid them in navigating and emerging from moral distress. One participant shared how she has found herself utilizing specific and routine methods to tease out the facts that she needed to help resolve the moral incongruity linked to the situation. She stated,

> I've become very process driven so when moral distress happens my thoughts are ok how is the patient, and get your facts straight. Do your homework on what happened, find out more about the situation. I've become very black and white for two reasons. One to make it so the employee(s) sees it as black and white and two, for my own personal well-being. It takes the emotion out of it my job. As a leader I need to be objective and supportive. (P1)

Multiple participants voiced the importance of fact gathering, which included collecting collateral information from documentation (e.g., patient medical record, safety learning documentation), reviewing staff scheduling, utilizing policies and documents, and interviewing patients, family members and staff involved (or associated with) in the situation. The importance and immediacy for follow-up was also identified as a key element as was the leader's ability to be present and visible in the clinical environment. If the situation was a sentinel event, the importance of holding a critical incident debriefing and a critical review was also valued as leaders noted this facilitated the well-being of those involved and aided in determining the full context of the situation and the required learning opportunities to prevent similar situations. Sharing the learnings and outcomes for staff after critical incident reviews was also found to be highly valued by nursing leaders and verbalized as helping them resolve their own moral distress. Another method that leaders emphasized as fundamental to helping not only themselves

move out of moral distress but also their followers was the importance of being supportive to all, not only those who are directly involved but the entire team. A poignant example:

> First, I made sure that the patient was the priority and ensured the patient was moved into trauma and was intubated and all that piece. I also made sure I supported that nurse who had discovered it because she didn't really want to say her co-worker hadn't done his job. I had her review the other charts with me because she took over and I said do you see something in here? She said you're very upset and I said yes I am, that's not who we are, that's not the kind of practice that I want us to give, that's not the kind of care we want to give. So I said yes I'm upset and I told her, I'm disappointed but I said I need to make sure that you're ok. I know she doesn't want to tattle on her co-worker. She is also upset at how sick her patient was. She is a very strong nurse who hasn't been there very long but she is not afraid to say this patient's really sick and I've got to tell someone. So it was interesting how I spent time with her to support her in a different way. (P1)

Pause and/or sleep on it (if you can!). Participants reflected on the power of time, patience, and pausing before acting as a strategy in navigating moral distress. Many emphasized a strong appreciation for this strategy as it had the ability to change the situation and ease tensions. These elements also brought clarity and perspective to the whirlwind of emotions, thoughts, and elements involved in moral distress.

> When you are in high moral distress, it's best to actually take a day or so to think about things more clearly than dealing with them. This is connected to reflection and time to get the whole story. No reactions, just let me think about it, let me mull it over, 24 hours isn't going to hurt and it will also give you time to be able to debrief yourself. (P7)

One perceived benefit of carving out time during the moral distress experience was that it helped preserve relationships and allowed one to gain control of emotions that could lead one in the wrong direction.

> I have certainly had some interactions with managers of other programs where afterward I reflected and thought I could have handled that better. I was emotional at the time. I should have walked away and thought about it before I responded. In the heat of the moment when you are upset or if something you don't believe in is going on, you think other people aren't doing what you believe they need to do, then I've stepped back and said "Oh that was dumb. Why did you say that?" I also think I need to give myself permission to take time off, to let me be emotional and think. You don't have to be up every single day, and you can give yourself permission to say "You know what, it's ok, I need time." (P1)

Exercising patience was another technique considered as important in navigating moral distress. The internal strife caused by the emotional turmoil inherently triggers one to want to react. By taking time and pausing or sleeping on it (if you can, as sleep pattern disruption was one of the physical symptoms of moral distress), participants were able to move forward and stay in control as new information sometimes emerged that allowed decisions to be made more easily.

> I think you have to be patient; I think you have to be tolerant and trusting in yourself, in your ability to do the best that you can and be ok with that. I think you have to accept that and know who you are and just recognize that you're doing the best you can and that's all you can do. Some things are out of your hands and I think if you don't have that kind of approach to things it will just eat you up. You'll just be so frustrated and angry all the time. You've just got to learn to try and let things go. (P9)

Connecting and building solid teams. The importance of connection and building strong solid teams was another common strategy, supporting the importance of building the relationships quickly within and outside the team. The value of connecting in relationships was reported to have multiple benefits. Some expressed the benefit as the transfer of support and knowledge. Several participants reflected on their early days as a leader and the naivety in not knowing where leadership supports were found in an organization. This was described as a learning process of trial and error and one supported by nursing mentors. Another benefit of building strong connections was participants feeling they could garner honest feedback and opinions during times of moral crisis. As one participant stated,

> I have never been one to think my way is the right way. I want critique. I want people to give me their opinion. It's important to me to hear what other people think and I usually learn at least one or two gems from every conversation- well here's how I would do it, and have you thought that it could be interpreted this way? So it's really important to reach out to others and I have chosen people who have opinions that are different from mine and I value their opinions. (P1)

One of the techniques to help navigate morally distressing situations that one participant shared was storytelling. She explained that through the power of storytelling she was able to

bridge the silos in the health care system by sharing patient experiences or situations. This assisted her during an intense situation where moral distress occurred in the critical care areas. It is through sharing the stories of people and staff that she finds strength to cope with moral distress.

> I do share and collect stories about what's happening in emergency with patients. I also invite other managers from upstairs to come and walk through the ED when it's insanely congested so when they are getting pressure from their bosses, they can say 'Actually you need to go down to ED and have a look.' I think a visual really helps people and then it's like "Oh I get it!" You have to kind of keep bringing it up, and I try to do it in a very non-emotional way, like it's hard for your guys, I understand running four extra beds is hard but by you closing them this is one of the things that will happen in ED today which extends beyond our walls. (P7)

Building high-performance teams was one of the preventative strategies that many senior nursing participants mentioned when discussing what helped them navigate and emerge from moral distress. High performing teams were described as "inter-professional," "tight-knit," "aligned with a common purpose," "patient-centered," "shared leadership," "shared values and norms," "open communication," and "trust." Actions or behaviors identified in these groups included openly talking to the team about leadership challenges, feeling safe, building supportive relationships, showing vulnerability as a senior leader, and building a sense of support and community among team members. When asked to reflect on the value of high performing teams for nursing leaders, multiple interpretations were offered. First, many talked about the importance of distributive leadership, which meant having people in place so that they can do the things that need to get done when the leader is not present. As one participant stated, "You have to do that otherwise you will worry about your areas and not be able to achieve work/life balance" (P2).

The second articulated benefit of high performing teams was the cohesiveness and collaboration that existed in the team. Members are united by a common goal that facilitates

trust in one another, creates a sense of team identity, and builds confidence in individual abilities and effectiveness, within the team and between the team and leader. Reflecting on her experience of building and participating in a high performing team, one participant stated,

> I truly believe it is easier to turn it off when I know that I have built a solid team around me. It's harder to turn off when I feel fractures in the team. I commit a lot to building my teams, a huge amount. If the right people aren't there, I will move people on to the next step respectfully, what that looks like, have the conversation. I really feel that the strength is in the team and then allow all team members to detach by being able to rely on their team to pick them up. (P18)

Leadership actions in relationship. Participants were asked to discuss their actions that they perceived assisted them to emerge from moral distress. In all 32 interviews, some type of action was taken to address the moral incongruence and conflict the participants were feeling. The most common action taken was discussing the situation informally with peers followed by discussing the issue with their supervisor. Participants clearly valued the opportunity to connect with others to prevent isolation and foster relationships so that they had others to go to during times of moral distress. Another individual reflected on how, over time, she learned the art or process of prevention. She went on to explain:

> I'm a real preventative type of worker in my approach to a lot of what I do so I try to anticipate and prevent the problems from happening. Certainly being very in tune with my front-line leaders so if there is an inkling that something is happening that I get alerted sooner than later and then I get the right people involved to really listen from the start. I have also learned to set boundaries. I have worked with so many complex and dysfunctional family dynamics that I know where the resources are that can come in and meet with us and help me set boundaries. I have even consulted with the ethicists. (P10)

Emerging from moral distress takes work—emotional, physical, and self-work. Ownership of the experience and resolving moral distress was a self-initiated process. Participants shared that character traits such as "being strong," "being an optimistic person," "looking for the good or opportunities," "being proactive," and "using a preventative approach" were keys to navigating through and out of moral distress.

> I have been in health care for a long time and quite frankly, I haven't seen this level of distress in over the 20 some odd years I have been doing this. I think you can support all you want but until you yourself actually deal with the problem, you're not going to fix the moral distress. (P9)

Another common action that was taken to navigate through moral distress was connecting and interacting with the staff involved in the situation. Being present and engaged in active listening and myth-busting not only allowed employees to vent, but it also demonstrated that as a leader one was aware and involved in the situation. Maintaining visibility and presence with staff during the emotional turmoil of moral distress was important.

> I think presence is important. I think to be able to go down and talk to the staff, find out is there anything more I can do for you or how can I support you, is important. It is acknowledging that they are going through stressful times too and that we as leader care for them. That just helps in their delivery of care is better especially if they think or know they are being looked after. (P7)

Finally, one last action that aided participants was taking time to observe during the experience or reflect on the lessons learned from the resolution.

Setting limits to work/life relationship. While all participants noted the importance of setting work/life limits as a wellness strategy, many acknowledged that this was one of the most difficult strategies to regularize and enforce during morally distressing situations. The role of nursing leader can be an "all-consuming" or "draining" experience with moral distress naturally being "just part of our jobs." Many spoke of the tension between organizational expectation of immediate response times and unrealistic workloads and the struggles that they had in balancing these elements. While participants understood the workload demands of the role, several remarked that they had to be very intentional when setting limits between work/life relationships.

> I put in hard perimeters around hours being available for work because if I don't I find the expectation is almost a 24/7 availability. I will scan my e-mail messages at night, and I use my judgment if it's urgent I respond and if it isn't I actually ignore it. I feel it is teaching people how they need to expect that I will show up and I'm trying to role model balance in my own life. It's hard some days because leaders at a senior level above me,

> some of them will e-mail at 10:00 at night and want to know something by 6:00 the next morning. There are people who are extremely reactive and I'm not that way. I look at it and use my judgment, like does that person need to know this information tonight, is it critical to operations tonight or tomorrow? I've become very protective of my time outside of the 50 – 55 hours of work I put in. I very rarely check my e-mails on weekends. I figure if it's burning and important somebody will call me. What I'm recognizing now as an outcome from that is that I'm behind on a lot of work, behind on deadlines, behind on e-mails because it's very challenging to keep up with the demands in the hours of the day that are there without actually breaching that perimeter that I have put in place for myself around personal time. (P15)

Decision-making. All participants commented on the complexity surrounding decision-making present in health care due to enhanced medical technology, an aging population, increased acuity and co-morbidities, complex social and family dynamics, and a reductionist demand for a cost efficient system. Participants shared they look to the greater good to help make these complex decisions within their role. Techniques that helped decision-making during times of moral distress included collecting as much information as possible, such as understanding the full context of the situation and exploring the relevant clinical issues, such as the patient's history and quality of life, the goals of treatment and how the patient benefits from medical or nursing care, thus avoiding further harm. Secondly, participants also shared the importance of exploring as many options as possible to determine any consequences of the decision taking into account, the good or bad consequences for the team, organization, and all affected. A third technique that many utilized was staying patient focused during the decision-making with patient safety always trumping financial gain. One of the internal struggles that leaders often talked about was the risk of individual patient safety versus the greater good.

> I've come to discover in my own leadership journey that having respect for the human dignity shouldn't be negotiable and doesn't have to be even with those other pressures in the system. What I've come to realize and accept is sometimes making patient-centered decisions, with all those other pressures, doesn't always mean a decision is best for an individual patient and their needs and desires. Sometimes making patient decisions is

> about looking at the broader population and making decisions that will have a positive impact on a larger group over time. I've been able to find a way that I can actually do that, sometimes it's situation by situation, sometimes it's a broader population situation but I've been able to do that by listening to my own instinct and internal antenna around whether or not those values are being compromised. I'm a big believer that instinct is not an airy-fairy piece. Instinct and intuition actually have very scientific foundations that we are just starting to understand. In a nutshell, it's kind of doing that check back to say ok is this respecting human dignity and is this being compassionate and kind and sometimes by doing that, it has actually made me change course. Depending on somebody's situation, I have made decisions that have not been in the best interest of the population but it has been in the best interest of an individual or family. (P15)

The implication from this participant's reflection is that leaders also rely on their ethical principles and values as they make decisions. Supplementing this was the need to seek support from colleagues, supervisors, and other resources such as ethics committees. As one participant noted, involving other resources to help one in making difficult decisions is important. One of the realizations shared was that "the organization was unaware of how difficult these morally laden initiatives were for those on the front lines trying to enact the directive of the organization and government." As one participant reflected on a very difficult initiative she oversaw, "The best part of the ethics committee meeting for me was when the ethic chair acknowledged how difficult it must have been for the leaders to enact and implement that program" (P18).

Self-care. With each story of navigating through morally distressing situations, participants understood the importance of self-care yet acknowledged that they were inconsistent in following through with self-care actions. In fact, from the participants' perspective there was a commonly held belief that nursing and other leaders engage in unhealthy behaviors. As one participant stated, "I see and hear of senior leaders engaging in really unhealthy behavior . . . from overeating, lack of exercising, and lack of caring for themselves. A common thing I'll hear is, let's go have a drink" (P5). While many felt they needed to spend more time on self-care, some asserted their diligence in self-care. Several commented on the importance of

daily exercise to assist with stress management as well as refraining from eating at their desks and making smart food choices. One noted,

> I've learned to put things a little bit more in perspective but I've become an absolute believer in several things, they are just absolutely critical. Exercise, you've got to do it every day 20 minutes go for a walk, some meditation time, quiet time, I drive to work and I listen to relaxation tapes, setting up a psychological boundary in one's mind, reminding yourself that this is beyond your control, knowing what my ethical framework is and being really clear about that with people I care about. One must make sure that you remember that life is finite and that this is my role but this is not my life- that's my family, my friends, my health. (P5)

Other intentional strategies participants found helpful to navigate through moral distress were booking activities to leave work (e.g., appointments, gym time), taking the time during commutes to listen to music or audio-books, and reviewing schedules for the next day before leaving work in order to identify challenges.

One of the final elements of self-care that had a significant impact in assisting participants in navigating through moral distress was maintaining a positive mindset amidst the chaos of the ethical whirlwind. As one participants stated, "Although the outcomes are sometimes negative, I always try to find something positive in it" (P 24). More specifically, one participant shared an experience where everyone on her team was exhausted after working through many weeks of severe overcrowding in an ED.

> I tried to find the positive and look for things that make me happy, when I see staff that is engaged and doing a good job, I love fanning the good so just acknowledging people makes me feel good. Also personally I would do stuff at home, I love art and being outdoors so just doing more of that. I'm able to just let it go and go and do those other things to just keep resilient and happy. (P10)

Accessing and utilizing organizational resources. Leaders reported three sources of support from organizations as important for their ability to navigate through and out of moral distress. The first was access to the support of HR. This resource was viewed as critical for navigation as many situations involved significant performance issues involving collective

agreement interpretations, human rights requirements, and other employment contractual interpretations. As one participant poignantly stated, “I didn’t study labor laws, I studied nursing so I feel like I’m lost when situations involve complex HR issues, so I need the help of an expert” (P10). This resource varied across health authorities. Several shared how their organization provided active (hands-on) HR consultants who worked alongside them during labor issues, which they found very supportive and helpful during difficult situations involving moral distress. Others reported significant frustrations in accessing services. For example, one participant shared how her inability to immediately access HR contributed to the moral distress of the situation for her:

> In our organization, the process to get help from HR is ridiculous. We have to put in a request for help which then gets filtered and then a week later the consultant assigned would call you. It is ineffective and makes the job even more difficult and stressful in this 24/7 industry. (P14)

Having prompt and timely access to HR services was strongly recommended to mitigate moral distress by participants who had difficulty accessing this service.

The second resource viewed as important was having access to ethicists or ethics committees, organizational development consultants, and HR consultants/associates to conduct performance attendance meetings. All participants saw the value of ethics support although many noted that in the fast paced current world of clinical practice, engaging ethics assistance was occasionally delayed, which was frustrating. In addition, the leaders commented on the importance of having the appropriately skilled professionals in these support roles. One participant stated, “When you call for help, the last thing we want is the same question reflected back on us that we are struggling with, we need help with the answers. That isn’t a help and only continues the spiral of the moral distress.” (P14)

The final resource valued by participants was the recognition and processes in place to support quality practice through quality review committees and safety reporting mechanisms within the health system. As one individual remarked, “It’s done better now. Instead of leaving just one or two leaders to manage these adverse events, the organization brings in a number of people to help do the heavy lifting. It’s shared.” (P21)

While participants shared a wide array of strategies, what became evident from listening to the participants’ stories was that these strategies were organically self-taught and refined with each new experience of moral distress. There was no little black book or reference source that clearly guided leaders through moral distress. In addition, there was an underlying resourcefulness within the strategies that fostered further coping strategies during periods of moral distress.

Lessons learned. When asked about lessons learned from morally distressing experiences, participants identified a variety of responses. Table 4.5 summarizes the lessons learned (sub-themes) from the participants and also includes the overarching themes: a positive growth mindset or a negative mindset.

Table 4.5.

Condensed Meaning Units, Sub-themes, and Main Themes of Lessons Learned from Moral Distress of Nursing Leaders

Condensed Meaning Units	Sub-themes	Main Themes
• I have learned these experiences are just a phase, that I just have to go through it and cope and I will come out of it and be ok and survive (P10) • I know we will see and do hard things but it’s how we work through them that helps build team and how we support each other. My biggest learn is that you don’t have to know everything, you have to be able to listen, bond and give some direction to people, and know there will be an end (P14)	***Resilience***	
• I’ve learned that I will be a little more cautious and wiser in my ability to make sure I’m surround by good people and when I don’t feel this then I need to go (P18)	***Trust Wisely***	
• One of the things that has always come through in my life is I’m not much of a risk taker. I think sometimes these moral	***Importance of Risk Taking***	

Condensed Meaning Units	Sub-themes	Main Themes
distressing events are because I have been pushed into having to make a decision over a really difficult situation. So the positive out of that is being pushed into those, because I think I handle them well, maybe don't give myself enough credit for that. When I'm actually forced into those situations and say that one worked out pretty good, I find that very rewarding for myself (P2)		
• If we are willing to be vulnerable and authentic in our leadership we allow ourselves so much more opportunity to really learn, to really bring in that meaning and to make connections that are important to the work we do and most importantly filter down to everybody we meet (P5) • Be armed with as much knowledge as you can from a business and financial perspective (P22) • I think I'm learning where I need to target growth and evolution in my own change management capability and some of that is enmeshed in my own personal experience. I'm still trying to define in both cases how do I learn to deal with that better in order to be a positive leader in the system and at the same time being a genuine leader and person (P15)	***Importance of Continuous Learning***	**Growth or Positive Mindset**
• Sometimes the moral distress or the whole distress in some ways empowers you and it moves you forward. If I look back in some ways it's actually given me impetus to stand up and say we need to be counted here and it has given me a voice on occasion that maybe I wouldn't have otherwise have had (P21)	***Creates Empowerment & Confidence***	
• My past experiences have contributed to that growing repertoire that I have and repository that I have to pull out of. Where the greatest learning for me has been and where I pull out of the most are those times when I did not listen and made decisions or supported decisions and it back fired, they weren't the right decisions because it really didn't make that much of a bigger difference in the larger whole but a family or patient ultimately still suffered for it or didn't quite get the experience they needed because of it (P15)	***Experiential Growth***	
Condensed Meaning Units	Sub-themes	Main Themes
• Just going in with that kind of attitude that, just do the best you can and knowing that you did. If you are constantly battling with things you're just going to drive yourself crazy. If you just do what you can do and are satisfied with that, you have to find a way to be satisfied with that (P9) • Yes because I'm more assured of what I stand for and that I will not step below that. (P1) • It was morally distressing that I felt the care providers didn't put the same emphasis on patient safety as what I valued (P11)	***Knowing Who You Are; Recognizing Others Hold Different Values***	
Condensed Meaning Units	Sub-themes	Main Themes
• I guess I've done it a number of ways either by working with and speaking to my colleagues both medical and nursing and trying to come to the best solution depending on what it was. Collaborating was the key (P21) • Find an unbiased confidential ear. As nurses, it should be a nurse who understands the professional autonomy, responsibility and accountability engrained within the role. It can be with an informal or formal role but you need a safe place to spout off to that holds your confidence. A place that I can lay it all out an it would not be incriminating but would be supportive, helpful and understanding on how to work through certain situations (P18) • Don't hold it in or hide. Find someone to talk to about it. Find a safe place and share it with somebody because I guarantee someone else has had a similar experience and can either support or provide you with solutions (P7)	***Importance of Collaboration & Coalitions***	

Quote	Subtheme	Theme
• I've become good at being able to take a system's approach, trying to perceive situations from multiple perspectives, multiple lenses and I've also gotten good at compartmentalizing and recognizing that obviously there are patterns of moral distress that I would look at differently but compartmentalizing it means I can often take something that I'm not ok with and that I will not be ok with and put it aside, not always, but I am able to do that without it impacting or without it freezing me or paralyzing me from doing the rest of my work (P15)	***Systems Approach & Compartmentalization***	
• I think from a leadership standpoint that is one of the most important things is either to stand beside them, stand behind them or be out in front of them when they need you to be out in front of them. I guess it's about courage, not knowing whether you can help or not but just being there. That's one of the most important things that I learned (P19)	***Courage***	
• I have very little influence in changing this situation so I'm trying to learn how to live with that and not get so emotional all the time. Not letting it affect me as much as it does and that's a real struggle for me. You know me, I like to do things to make it easier for patients and families and that does frustrate me (P4)	***Disempowerment***	
• Moral distress changed me. I've lost something, maybe innocence. As a leader I was disappointed as it came to light for me how political and self-serving leadership a can be. It made me sad how people can manipulate others. I'll never let this happen to me again and I really questioned whether I wanted to continue (P3)	***Loss of Innocence***	**Negative Mindset**
• You get mad because nobody is doing anything, why isn't this changing, why isn't it getting any better? (P17)	***Anger***	

Most participants revealed a positive growth mindset emerging from moral distress. They employed a wide lens to the situation and asked themselves, "How can I grow and learn from this situation?" They believed they had grown through the experience regardless of success or failure. Many participants openly admitted that during the experience there were significant challenges, negative emotions and feelings, and physical symptoms; however, they were able to reflect on the experience and acknowledge that they could learn from it and draw on the experience in the future. While these individuals acknowledged frustrations and other emotions associated with the experience, they expressed continued job satisfaction and a desire to continue to make a difference for patients and the delivery of patient care.

A few participants' reflections shared a more negative mindset of moral distress. Reflecting on the morally distressing experience, they experienced an overwhelming emotional and physical exhaustion, self-doubt, a decrease in job satisfaction, and a disparaging view of the

situation, context, or health care system. One questioned if she belonged in a leadership position and if she had the ability to do the work due to her feelings of discouragement over the situation. She stated, “I still have those days today. I think we all do. You know when you ask yourself am I really good at this job?” (P18). Another individual shared,

> It (the experience) still bothers me. I can cope with it because I don’t have that site anymore. In the new reshuffle that’s not part of my portfolio so I’ve kind of let go of it. It was a factor in my decision about which job I was choosing. I didn’t want that to be part of it because I knew it was kind of a dead end there. I wasn’t going to be able to make the changes I wanted to see happen. (P9)

Together with the sub-themes identified in Table 4.5, the main themes add depth to the foundational elements of moral distress in nursing leaders.

Recommendations of nursing leaders. One of the research questions of this study was to garner institutional, professional, and personal approaches and resources nursing leaders recommended to address moral distress. The participants were very clear in their recommendations, which are captured in Figure 4.7.

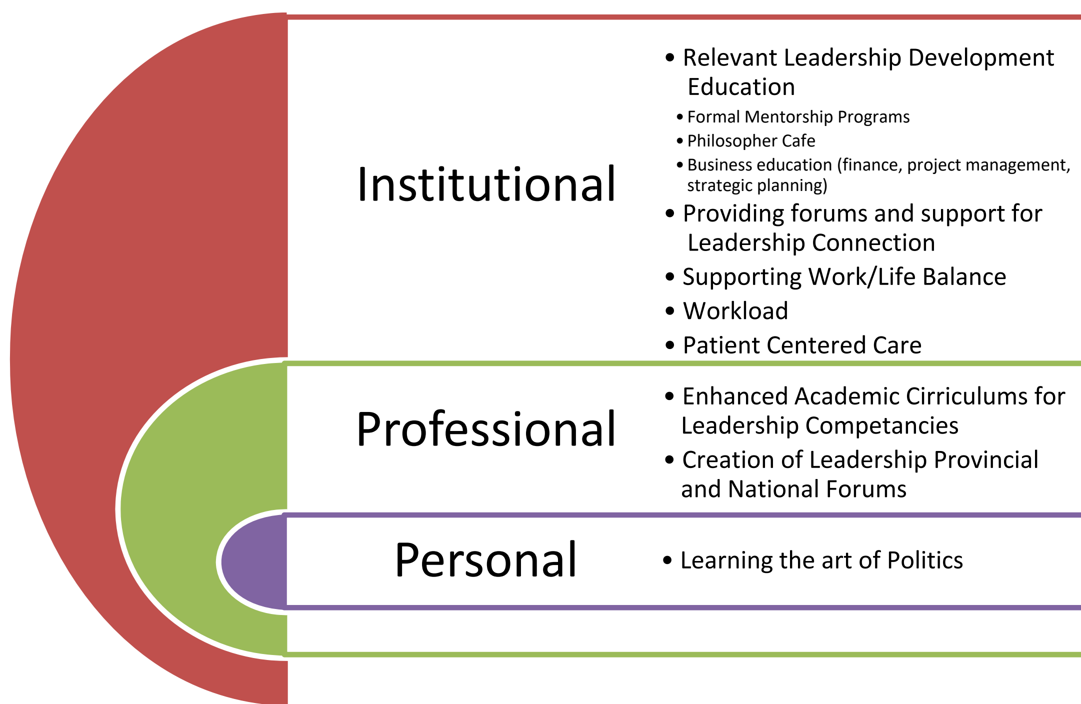

Figure 4.7. Nursing leaders' recommendations to address moral distress.

Participants shared multiple recommendations for institutions in order to address moral distress among its nursing leadership. The strongest sub-theme in this category was the need for relevant leadership development education. This education included a formal mentorship program. One participant stated, "I found the mentorship and coaching my peers provided me to be very helpful especially when I had to navigate through a complex change shortly after I started when there was a lot of moral distress" (P15). Participants also advocated for applicable business education to facilitate strong business acumen, project management skills, conflict resolution, and strategic planning. A second institutional recommendation was the creation of leadership forums within the institution to support leadership connection. The value of this was perceived to foster shared learning, relationship building, and increased awareness of available resources. Another recommendation was encouraging institutions to support a manageable work/life balance. Participants shared that there was an unrealistic expectation of 24/7

availability and immediate response time excepted of leaders after-hours and during vacation. As one participant shared,

> I think there is a bit of an oxymoron out there because they say make sure your blackberry and everything is off after eight hours, but then if you're not available and you don't answer it's like why didn't you answer? I really needed you this weekend. Why didn't you get that done? Why didn't you do this? (P3)

A manageable workload was another consistent recommendation. Many articulated that span of control was too broad within health care and that leader workload in the form of additional resources was required. Finally, many expressed that institutions needed to refocus on patient-centered care to help eliminate situations of moral distress. Participants reflected on the noticeable current shift within institutions regarding a reductionist demand for cost effective care, creating conflicting between professional and corporate values. One participant shared,

> I think we could maybe learn from some other organizations that are successful in preserving their leaders. I look at one of my colleagues who work in a different health organization and see how happy she is. You've got to wonder "Why are you happy?" She gets the support that she needs, that's why. That organization is truly centered around the patient. They really focused on the patients and try and do what they can to support that. When they go into budget meetings it's not really about the money it's about what do we really need to do for our patients and how do we do this? I don't think we have ever had any finance meetings like that. It's like where are you at, where can you get money. That just creates an atmosphere of people always fighting for things, fighting for resources rather than doing the right thing. (P9)

When it came to recommending professional resources, there were two suggestions. The first was to enhance the current nursing curriculums to support leadership competencies in undergraduate and postgraduate courses. One of the suggestions tied to this recommendation was to link the curriculum to relevant organizational leadership competencies such as business acumen, labor relations and change management. The relevance of this was shared by one participant who stated,

> There is stuff coming at us all the time from the Ministry of Health and we have to be responsive, we have to do things I never went to school to do. I went to school as a

> young woman thinking I was going to take care of people, love people and make sure that they had the best care that they could get. Now I'm studying data, I'm looking at metrics and looking at our performance constantly against quality based procedures we have here. There's so much more lingo and broader educational requirements needed now. The nurse that I was and the nurse that I am, wow, are worlds apart! (P23)

The second professional suggestion was the creation and sustainment of leadership forums both provincially and nationally to discuss leader focused issues relevant to practice and current issues in health care.

Finally, in terms of recommendations at the personal level, the significant sub-theme was learning the art of politics. Those participants who had been leaders for a long time echoed the vital nature of being politically savvy as an element of survival and success in their leadership roles. One participant noted she used an executive coach to assist her in her leadership behaviors in the workplace by having the coach observe her in meetings to observe and critique her leadership style, tone, communication techniques, and body language. Understanding the political culture and how one reacts to it was important as she wanted to make sure she knew her triggers and what her reactions were in the workplace. "Ultimately I think no matter what you see or what you're doing, it has to be interpreted in a very politically correct way or it can be detrimental to your career" (P17). Describing the skills required to "get a pulse" of the politics, one participant noted,

> One must be intimately aware of the political environment-your immediate environment, the larger system and how do you navigate that and navigate it well. You don't want to play on different people's beliefs, but just by being aware of what their values and beliefs are and understanding that is important. It allows you to understand why there might be a group that is exerting a certain amount of pressure in one direction. Gaining a better understanding and appreciation of other peoples or groups of people and what are their main drivers are helps me navigate the climate. (P17)

Mahatma Gandhi (1958) once said, "Knowledge gained through experience is far superior and many times more useful than bookish knowledge" (p. 397). This is true within the

practice of nursing where experiential knowledge strengthens our base to build new knowledge. This study specifically captured the voice of nursing leaders around their recommendations for mitigating moral distress within the role of nursing leader. These recommendations provide knowledge for organizations, policy-makers, and individuals to consider when supporting those leading the health care system.

Summary of navigating and emerging through moral distress. Through the stories of this study's participants, I have identified strategies used and lessons learned by nursing leaders to navigate through moral distress. These strategies included the following: developing and refining self-knowledge, critical self-reflection, pause and/or sleep on it, tactical process approaches, connecting and building high functioning teams, leadership actions in relationships, setting limits, informed decision-making, self-care, and engaging other resources. These strategies were typically self-taught and organically refined with each new experience of moral distress. In addition, there was an underlying resourcefulness within the strategies that fostered further coping strategies during periods of moral distress.

Experiential lessons from morally distressing situations were also identified. While there were two main categories to the lessons learned, a positive growth or negative mindset, several sub-themes of lessons illustrated the resiliency, trust, risk-taking, continuous learning, confidence, experiential growth and flexibility, self-awareness, collaboration, and courage that are required during moral distress. These sub-themes provided depth to the foundational elements of moral distress in nursing leaders.

Recommendations from nursing leaders that can inform organizations, policy-makers, and individuals on how to mitigate moral distress for those leading the health care system also emerged.

Chapter Summary of Findings

The purpose of this qualitative interpretive description study was to gain further contextual understanding of moral distress by capturing first-hand experiential perspectives of nursing leaders that illuminated how they interpret and make meaning of their experiences of this phenomenon. The findings revealed a rich and complex account of moral distress contextually framed through a leadership lens within health care. Through an iterative process I identified the metaphor moral distress as an ethical whirlwind, which facilitated an understanding of the overarching experience for leaders and also identified three conceptual patterns that assisted in defining this metaphor.

The narrations of the participants emphasized six significant findings according to their interpretation of their experience of moral distress. First, instead of focusing on describing the right ethical action or constraint, participants emphasized their entire experience of moral distress. Simply put, moral distress was more than an “it” one has or does not have. They shared what the experience of moral distress felt like, how it physically impacted their lives, and what the experience meant for them as leaders and nursing professionals. Participants understood the experience to be an all-consuming and embodied experience involving their emotions, body, and mind.

The second prominent finding was the profound nature of the experience and the need for a solid and strong personal/professional ethical framework. Although personal frameworks were challenged during morally distressing times, these frameworks ultimately provided these participants with a sense of direction and stability as they navigated through the situation. A third finding was how several participants believed that in today’s health care environment leaders cannot economically afford their values due to the political environment. The perceived

political complexity and negativity of the health care leadership climate contributed to nursing leaders' moral distress. On a more granular level, participants reflected on what this was like for them when they identified elements that contributed or influenced their moral decisions, including the presence of levels of politics, outside organizational influences with power, bias within the organization, and the leadership tone.

A fourth finding is that nurse leaders are just as vulnerable and susceptible to moral distress as other health care providers. They suffer from moral distress and may, in fact, suffer more than others because of the number of people they are accountable to and the responsibilities inherent within their professional role. The fifth finding is that each of the external and internal factors identified in this study exerted a significant toll on participants and significantly contributed to moral distress. The final finding is that moral distress is a situational experience of varying duration. The experience is suggestive of turmoil, anguish, pain, and an extreme intensity, encapsulating the experience extending across all leadership levels with an increased susceptibility for middle managers due to the proximity to the patient and span of control.

During this study, I was able to critically observe and reflect on the participants' accounts and identified areas of relevance about this phenomenon as it applies to moral distress and nursing leaders. From these actions, eleven further findings evolved:

1. Moral distress was a deeply personal and subjective experience that was crushingly overwhelming and confusing and dependent on proximity to patient, larger socio-political power dynamics and previous individual experiences. It has potentially significant long-term physical and emotional effects on individuals.

2. The depth and intensity of the emotions displayed clearly revealed the importance of the need for leader support as nursing leaders manage and lead through difficult ethical situations as well as mitigate negative impacts on health and well-being.
3. Moral distress within nursing leaders is experienced as a tumultuous vortex of constantly changing variables in continuous dynamic interplay involving the patient, ethics/values, politics, the organization/health care system, and relationships (patient, families, staff, and society). This experience was contextualized as a period full of intense energy and motion occurring both within and between the individual (internally) and the organization (externally).
4. Nursing leaders wrestled with a multitude of ethical tensions of varying intensities on a micro (patient), meso (organizational) and macro (community/provincial/national) level. It was precisely this myriad of varied ethical tensions paired with the nurse leaders' commitment, accountability, and responsibility (organizationally and professionally) that participants believed contributed to or created their feelings of moral distress.
5. Fear, workplace incivility, and violence were present within the leadership culture itself.
6. There is a repressed culture and stigma regarding the experience of moral distress within the leadership culture.
7. The ubiquitous nature of moral distress within the nursing leadership culture speaks to the relevance and need for institutional attention on how to mitigate the experience and support the leaders.

8. Multiple relationships, during and after moral distress are crucial in navigation and meaning-making for nursing leaders. Enactment of moral agency was supported through positive relationship. The supervisory relationship was most integral to the experience of moral distress with the peer relationship providing significant support for the leader during and after the experience. This study is believed to be the first that illuminates aspects of dialogue with supervisors found to be supportive in working through the experience of moral distress.
9. The strategies and lessons about moral distress within the leadership culture are self-taught and organically refined with each new experience of moral distress. There was an underlying resourcefulness within the strategies that fostered further coping strategies during periods of moral distress. This speaks to how experiential learning and reflective learning are iterative processes.
10. There was a potentially isolating nature attached to the role of nursing leader during periods of moral distress due to the self-initiated autonomous process for resolution. Leaders must not only navigate themselves out of moral distress but also those they lead.
11. Resiliency, resourcefulness, and self-awareness helped nursing leaders navigate and make meaning from their experiences of moral distress, creating not only self-transformation, but also passing on the understanding of the experience to others going through similar experience; in doing so they provide professional mentorship.

In the next chapter, I will take the next step in the interpretive descriptive process to extend these initial understandings of moral distress to a more integrated interpretation that helps identify what these findings mean in terms of nursing leadership and why they matter.

Chapter V: Discussion and Interpretation of Findings

Introduction

The goal of this research was to further illuminate a missing depth of understanding in the phenomenon of moral distress from a leadership context within the profession of nursing. I had the privilege to listen to 32 Canadian nursing leaders talk about their stories, perceptions, and experiences of moral distress encountered during their time as leaders in the current health care system. Compelling and poignant descriptions of events that involved significant adverse patient events, fiscal constraint, organizational conflict, access to and dwindling resources (human and structural), and larger-socio-political pressures and policy were summarized in Chapter IV. One overarching metaphor and three thematic patterns of ideas emerged from the research data: moral distress is an ethical whirlwind; leaders suffer, too; relationships matter; and there are ways to navigate and emerge from moral distress.

As a practicing registered nurse, the opportunity to utilize ID as the methodological inquiry appealed to me as it is grounded in a firmly ensconced nursing conviction that knowledge is not meant to be static but is constantly evolving. In addition, I wanted to bring the nursing leaders' voices into the discourse on moral distress and illuminate their experiential perspectives and ways of knowing about moral distress and allow the findings to address the "so what" (Thorne, 2008, p. 33) that drives all applied health professions. The aim of the research was to address three research questions:

1. How do health care nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian Health Care System?

2. What institutional, professional, and personal approaches and resources do nurse leaders recommend to address moral distress and how does the interpretation of those recommendations help us understand the situation of nurse leaders?
3. To draw from these findings, what are the implications for nurse leaders' real-world practices that promote the development of a positive quality of personal and professional life for leaders and what are the policy implications for institutional healthcare environments to diminish conditions that produce moral distress?

According to Sandelowski and Barroso's (2002) taxonomy of qualitative findings, the product of an ID study should generate a conceptual/thematic description or interpretive explanation that clarifies thematic linkages within the phenomenon to the applied field of practice (Hunt, 2009; Thorne, 2008). It is through the iterative process of data collection and analysis where bits of data eventually transform into patterns and then themes that personify the subtleties of experience (Sandelowski & Barroso, 2002; Thorne, 2008). Specific to this study, I drew on the theoretical knowledge I gained from examining the literature on moral distress as illustrated in Chapter II, coupled with my experiential and professional nursing and leadership experiences of moral distress, to critically examine the data from my interviewees and group and categorize the information. During analysis, I would ask myself the following questions: What ideas are starting to form? What is the data telling me? What am I missing? What is it I want to know and is there a relationship between that and what the data is telling me? (Thorne, 2014). This analytical process revealed ideas, concepts, and patterns of meaning that provided a more integrative understanding of the experience of moral distress (Sandelowski & Barroso, 2002; Thorne, 2008) This led to the interpretation of three patterns and an overarching metaphor.

The chapter's goal is to further transform the findings gleaned from this study from "telling what it is that [I] observed" (Sandelowski, 2000, as cited in Thorne, 2008, p. 47) to interpreting and concluding "what might this mean?" (Thorne, 2008, p. 49) and why it matters. Ultimately, the final step within any ID study is to return the product of the analysis back to the context of the practice field (Thorne, 2008, p. 50). This chapter begins with a brief overview of the three patterns and overarching metaphor of ethical whirlwind, followed by a discussion of my interpretation of them in relation to extant literature. It includes reflections on what I have learned during this practitioner-research journey including limitations of the study and my positionality. The conclusion discusses the implication of this study's findings through recommendations for nursing leadership practice and policy for institutions and government. Additional recommendations for future research are also suggested.

Interpretation of Findings

This study's findings align with the growing acknowledgement that moral distress is not an experience limited to front-line health care providers (Brazil et al., 2010; Gaudine & Beaton, 2002; Hamric & Blackhall, 2007; Kalvemark et al., 2004; Mitton et al., 2011; Schwenzer & Wang, 2006). Moral distress is a very real phenomenon that is present within the leadership role as well. A handful of studies have acknowledged the significance of moral distress as it relates to leadership (Ganz et al., 2014; Gaudine & Beaton, 2002; Nuttgens & Chang, 2013; Pauly et al., 2009; Rodney, Kadyschuk, et al., 2013), the relevance in terms of managerial functions such as priority setting and resource allocation (Mitton et al., 2010, 2011), and the relationship among the organizational environment and administrative policies and multiple job obligations (Porter, 2010). This study further illuminates the ontological experience of leaders by framing the emotions, feelings, and constraints of the experience. It also explored participants' perceptions

of the experience; the difficult moral elements attached to the situations; and coping strategies, learnings, and recommendations for addressing moral distress. To date, no other study was found that provides this unique context, thus revealing and enhancing the understanding of moral distress from a nursing leadership lens.

My interpretation of the findings was an iterative process steeped in critical and reflective examination of words, clusters of ideas, patterns of situations, sub-themes, and eventually themes. This was a dynamic and recursive experience where I would move in and out, between, and back and forth in a comparative way among details found in each interview. This was "excruciatingly hard work" (Thorne, 2015) due to the volume and depth of the data but allowed a broader contextual understanding of the experience of moral distress as nursing leaders understood it themselves. In the following sections, I present my findings and extend these initial understandings of moral distress to a more integrated interpretation that helps identify what they mean in terms of nursing leadership and why they matter.

Interpretation-moral distress as an ethical whirlwind. In order to close gaps in our knowledge regarding the complexity of the conditions that contribute to and influence the experience of moral distress, researchers have asserted that we need to shift our perspective from an epistemological focus of developing knowledge about moral distress to an ontological perspective that focuses on what moral distress must be like for moral agents (Musto & Rodney, 2015). Multiple qualitative and quantitative studies have examined the meaning, location (internal vs. external constraints), and contextual elements (e.g., frequency/duration/intensity) within front-line care providers as discussed in Chapter II. This study brings to the forefront insights into the ontological experience of moral distress within nursing leaders.

Instead of focusing on describing the right ethical action or constraint, participants emphasized common elements that captured their entire experience of moral distress. What this means is that moral distress is more than an "it" one has or does not have. Participants shared what the experience of moral distress felt like, how it physically impacted their lives, and what the experience meant for them as leaders and nursing professionals. Ever since Jameton (1984) first identified the concept of moral distress within the profession of nursing, researchers have continued to build a deeper understanding of moral distress describing the impact to the wholeness of human beings (Wilkinson, 1987), articulating the pain or anguish created (Nathaniel, 2002, p. 5), and identifying a felt experience representing an integration of mind, brain and the body, and emotions (Musto et al., 2014). These components were found to be aligned with participants' understanding of their experience. Furthermore, participants described moral distress as an overwhelming, all-consuming, felt experience that impacted their entire being.

Another finding was the profound nature of the experience and the need and reliance on a solid and strong personal/professional ethical framework. As discussed in Chapter II, the Canadian Nurses Association (2008) has maintained a code of ethics that serves as a foundation for ethical practice. With the increasing complexity of health care environments and patient care, this study's findings illustrate the reliance on personal and professional ethical frameworks and underscore the importance of and need for education on bioethics to maintain and support them. While personal frameworks were challenged during times of moral distress, they ultimately gave these participants a sense of direction and stability as they navigated through the situation. What was interesting was how several participants believed that in today's health care environment, leaders cannot economically afford their values due to the political environment.

The perceived political complexity and negativity of the health care leadership climate contributed to nursing leaders' moral distress. They reflected on what this was like for them, identifying elements that contributed or influenced their moral decisions, which included the presence of power and politics, outside organizational influences, biases within the organization, and leadership tone. Power dynamics and relationships in organizational environments are often difficult to detect and observe (Adams & Zanzi, 2006). These findings illustrate the underlying presence of power politics in organizational life and the need for leaders to have political intelligence. Several researchers have discussed the concept of political intelligence in management and the importance of acquiring this ability (Adams & Zanzi, 2006; Ferris, Perrewe, Anthony, & Gilmore, 2000; Hogan & Hogan, 2002). Understanding and assessing power dynamics in organizations is important for leaders to help them in decision-making and the mitigation of moral distress. This is new knowledge adding to the moral distress literature as it relates to leadership practice. Ultimately, these findings should give executive health care leaders, institutions, ethicists, and policymakers cause for concern and reason to actively collaborate to address the current system challenges and external constraints, while fulfilling fiduciary obligations, to prevent another incident similar to the Mid Staffordshire NHS Foundation Trust (Francis, 2013) experience discussed in Chapter II.

One of the interpretations made from the accounts of nursing leaders was that moral distress was a deeply personal and subjective experience that was crushingly overwhelming and confusing. Additionally, this experience was dependent on proximity to the patient, larger socio-political power dynamics, and previous individual experiences. The literature on the impact of moral distress on health care providers (Burston & Tuckett, 2012; Gutierrez, 2005; Hanna, 2004; Nathaniel, 2002; Varcoe, Pauly, Storch, et al., 2012) was clear about the negative emotions,

feelings, and physical symptoms of moral distress. This was consistent with the findings of this study, in which leaders experienced the same emotional and physical symptoms as those identified in the literature, with insomnia being one of the most prevalent physical reactions reported. What was interesting in this study was the conscious recognition and understanding of potential serious long-term health effects on health (e.g., cardiovascular disease, hypertension, and mental health issues) from moral distress. Yet, many continued to engage in unhealthy behaviors during periods of moral distress.

Another interesting finding was the belief by participants of the importance of controlling one's emotions as a leader and in harnessing one's non-verbal body language since, as leaders, they were supposed to be in control. This belief links to the undercurrent within the leadership culture to be self-aware of one's emotions and in managing these emotions as one moves up the hierarchy of leadership. This is particularly difficult when one is experiencing a confusing and overwhelming situation.

Another poignant insight, illustrating the depth and intensity of emotion, regardless of the passage of time, was the moral residue observed in some participants and its continued presence despite the passage of time. Webster and Baylis (2000) asserted that moral residue is "that which each of us carries with us from those times in our lives when, in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 208). In this study, moral residue was observed in approximately one-third of the participants as interviewees wrestled with significant emotional reactions while sharing and reflecting on their experiences. This was observed during the interviews either audibly (e.g., changing pace, rhythm, tone of voice, crying) or physically (e.g., flushing, physical restlessness, or trembling). The intensity of the emotions revealed the importance of the need for leader support as

individuals manage and lead through difficult ethical situations, as well as in mitigating negative impacts on health and well-being going forward.

A further finding, unanticipated by the researcher, was the impact of the emotion attached to the experiences shared, even by the study's transcriptionist. At midpoint in the transcription process, the transcriptionist shared how "heavy and painful some of the stories were to hear." Thorne (2015) refers to this as secondary traumatic stress (Kiyimba & O'Reilly, in press), which is attributed to reflections of painful human experiences like moral distress. This observation from the transcriptionist only reiterated the intensity of the situations leaders are exposed to, their vulnerability, and the life-long impact that these experiences can have on some individuals.

Heifetz et al. (2009) created a beautiful metaphor regarding leadership and perspective. In this metaphor the authors suggest "getting on the balcony" above the "dance floor" to depict what it means to gain the distanced perspective you need to see what is really happening (p. 7). As I step on the balcony and observe the dance floor of moral distress, I note several underlying professional meanings relevant for nursing leadership knowledge and practice. First, the findings substantiated the presence of a myriad of forces and tensions within the Canadian health care system that leaders must wrestle with to ensure patients/family, organizations, employees and community are cared for in the best way possible, as noted by previous scholars (Gaudine et al., 2011; Musto et al., 2014; Varcoe et al., 2012b). Reflecting on the evolution of Canada's health care system and service delivery provided in Chapter I, one can observe how the historical, political and social influences of society have, and continue to, contribute to moral distress within the health care system. Second, nursing leaders experience moral distress as a tumultuous vortex of constantly changing variables in continuous dynamic interplay involving the patient, ethics/values, politics, the organization/health care system, and relationships (patient, families,

staff, and society). This experience was contextualized as a period full of intense energy and motion occurring both within and between the individual (internally) and the organization (externally). Swirling in the center of the dance floor is an ethical whirlwind that represents the overall experience for nursing leaders including their emotions, physical response, and meaning-making. This experience of a whirlwind occurs internally and externally; whereby, dynamic non-linear continuous interactions and elements among the organization and individual are present. Difficult moral elements involved in their experiences, as well as personal transformation and experience, were further illuminated. The use of the term ethical whirlwind is a contribution to the literature of understanding.

This study contributes to the practice of nursing leadership in that it has provided insight into the forces and tensions that nursing leaders experience on a micro (patient), meso (institutional), and macro (community/ provincial/ national)-level that can affect enactment of moral agency. Paired with the nurse leaders' sense of commitment, accountability, and responsibility (organizationally and professionally), constrained moral agency and moral distress was a common concern voiced by participants. Given the professional and organizational expectation of nursing leaders to resolve and mitigate moral distress in the health care environment, institutions (meso) and provincial/federal policy makers in government (macro) must learn more about the current complexities of the internal and external tensions experienced by nursing leaders (and other health providers) and their relationship to moral agency, constraints in agency, and the well-being of individuals (patients, employees, and leaders) in the health care system. This study provided insight into the ontological experience or what it is like for nursing leaders as they experience moral distress. The challenges and tensions experienced by nursing leaders affect them on many levels (personally, professionally, and organizationally), which

highlights their need of support by institutions and governments. Furthermore, this is a critical dimension requiring attention in order for nursing leaders to provide the essential support for the ethical nursing practice of front-line nurses in the health care system.

Interpretation—nursing leaders suffer, too. Nursing leaders suffer, too, one of the patterns identified , illuminated participants' experience of moral distress in the leadership role, their understanding of what prompts moral distress (external and internal constraints), their lingering emotions after a situation, and their perceptions of the phenomenon. Several key interpretations about this are important to acknowledge.

First, nursing leaders are just as vulnerable and susceptible to moral distress as other health care providers. They suffer in similar and different ways from other health care providers. Scholarship over the last 30 years has been robust in describing external and internal constraints regarding moral distress in front-line health care practitioners (Cavaliere et al., 2010; Corley et al., 2005; Epstein & Hamric, 2009; Ganz & Berkovitz, 2012; Jameton, 1984; Rambur et al., 2010; Rice et al., 2008; Silen et al., 2011; Wilkinson, 1987). Participants did describe similar constraints that trigger moral distress for them as a leader (e.g., lack of knowledge and skill, powerlessness, fiscal constraints, lack of human resources, exclusion from decision-making). However, absent in the current literature, but apparent in this study, was that the challenges nursing leaders face at multiple levels of the health care system extending from a micro (patient/employee), meso,(organization) to a macro (community)-level. These included span of control, workload, organizational and professional regulating support, navigating a business-centric care model and political leadership culture, the overshadowing burden of potential blame, capacity and resource issues, and daily organizational risk. All contribute to moral distress specific to and amplified by the leadership role.

Furthermore, leaders may, in fact, suffer more or, at the least, differently from others because of the number of people to whom they are accountable and the responsibilities inherent within their professional roles. All participants in this study acknowledged that they had experienced moral distress and that they believed nursing leaders were not immune to the emotional turmoil created by ethically difficult situations. In fact, participants were very clear that it was not only very prevalent in the leadership role but could be exacerbated by the very leadership role. From the experiences shared, it would appear that leaders may be more susceptible to the phenomenon due to the juggernaut and complexity of the health care system and their role as a health care leader held accountable and responsible for management of clinical- patient ethical issues as well as the resolution of moral distress among the staff, department, organization, and larger community. As nursing leaders, they understood why situations created moral distress for their employees/department due to their own prior front-line experience, which was perceived to contribute to their own moral distress. They contextually understood the experience and were able to relate to the emotional, visceral feelings and moral components of the situations causing distress. Austin et al. (2005) argued it is this awareness and perception that plays an integral role in the development of moral distress, and the importance of this is in the receptivity and sensitivity to being aware that there is a moral problem that demands moral action as a professional. Participants shared awareness of the presence of moral distress in organizations when patient-centered situations occurred (even when not directly connected to the situation) such as controversial end-of-life decisions, critical events or trauma, disregard for patient wishes, and dealings with incompetent practitioners. This supplements current literature that commonly referenced these ethical situations within the environment among health

professionals in general (Hamric, 2012; Hamric et al., 2012; Johnstone & Hutchinson, 2013). This study adds nurse leaders to those suffering.

Front-line nurses and other employees often view leaders as those responsible for creating morally distressing situations for employees. While often viewed in the literature as the protagonist of moral distress for employees (Dodek et al., 2016; Gaudine et al., 2011; Wolf et al., 2016), this study's nurse-leader participants described the external and internal constraints restraining their enactment of moral agency and a perception of employees' under-appreciation of these constraints and the complexity of decision-making required, given available resources. This was described as also contributing to leader's moral distress. As discussed in Chapter II, scholars (Bell & Breslin, 2008; Corley & Raines, 1993; Shirey et al., 2008; Storch et al., 2013) and professional associations (Canadian Nurses Association, 2008; AACN, 2004) have consistently assigned accountability and responsibility to nursing leaders for the resolution of moral distress within the clinical environment. While leaders do have roles in mitigating moral distress, a broader system-level and collective approach (e.g., employees, all organizational leaders, physicians, policy-makers and government) for resolution of moral distress must be considered due to the complexity of the environment and evolving ethical patient care situations.

The moral distress literature asserts that the conditions that cause moral distress will vary among health care professionals as does its frequency and duration (Corley et al., 2005; Ganz & Berkovitz, 2012; Oh & Gastmans, 2015). This study echoes the same assertion through qualitatively developed findings. These contextual elements of moral distress were described by participants in this study. They understood their experiences of moral distress to be situational and of varying durations. The literature is replete with shocking stories describing the constraints within ethically difficult situations (Berlinger, 2013; Berlinger, Jennings, & Wolf,

2013; Edmonson, 2010; Nathaniel, 2006). Participants in this study also shared similar experiences suggestive of turmoil, anguish, pain, and an extreme intensity encapsulating the situation. What is clear is that moral distress is present within every level of hierarchy although the common perception expressed by participants was that the middle nursing manager role was most susceptible to moral distress due to proximity to patient and span of control. Participants highlighted the disparity of workload between managers and senior leaders, as well as across different health programs where varying care needs and demands of specific patient populations existed (e.g., emergency, critical care, maternity) that created larger workloads for these leadership roles. This supports the Mitton et al. (2011) suggestion that mid and senior-level managers appear to experience moral distress with similarities and differences in how their experiences manifest.

One of the observations made from the accounts of nursing leaders was the palpable fear and workplace incivility and violence within the leadership culture itself. While emotions/feelings like anger (Gutierrez, 2005; Wilkinson, 1989), sadness (Nathaniel, 2006; Sundin-Haurd & Fahy, 1999), anxiety (Elpern et al., 2005; Nathaniel, 2006), depression (Elpern et al., 2005), powerlessness (Nathaniel, 2006), failure (Brown-Saltzman, 2013), silenced voice (Edmonson, 2010), and isolation (Elpern et al., 2005; Wilkinson, 1987) were expected, the participants' descriptions of their fears (e.g., job loss/security, decision-making, and being able to afford their values) and incidents of incivility (e.g., shaming, undermining behaviors, lack of communication) and violence were surprising. Over half of the participants identified the presence of fear during a significant organizational change and attributed it to the culture of the current health care system. Regardless, these feelings and observed behaviors represent threats to their workplace and well-being. Further research on fear and workplace incivility as it relates

to moral distress are recommended, especially because the residual effect of moral distress contributes to job dissatisfaction, retention, leadership response, and physical well-being (Barkouli, 2015; Corley, 2002; Erlen, 2001; Hamric, 2002; Nathaniel, 2006; Wilkinson, 1987).

The analysis of the data also revealed the presence of a repressed culture and stigma regarding the experience of moral distress within the leadership culture. Kramer and Hess (2002) asserted organizational cultures discourage the display of emotion with the expectation that leaders be tough, calm, and resilient. This expectation appears to continue as all of the participants acknowledged the widespread nature of moral distress yet alluded to a hesitancy to openly discuss the topic in daily practice. A certain stigma emerged in the participants' stories, as well as a vulnerability of acknowledging moral distress as a leader. They shared their belief that for a leader to reveal her/his suffering of moral distress would have implications not only for the organization, but also for his/her personal career and well-being. The myth of leaders being in charge and in control at all times, both of themselves and their organizations, added additional stress to their ability to manage. The very fact of being in a leadership role inhibited their ability to reveal their moral distress. This is a new insight to add to the literature.

As I look from the balcony and reflect on the relevance of this study and why it matters to the practice of nursing leadership, I can't help but conclude that there is a strong dynamic and, at times, oppressive relationship between moral agents (nursing leaders) and larger socio-political structures that influence not only the individual, but also the delivery of health care. Moral agents are constrained by their own internal constraints and influenced and constrained by external constraints within larger socio-political structures within health care. A recent report from the United Kingdom serves as a powerful illustration of how individuals and structures can influence each other in a negative way (Francis, 2013). Musto et al. (2014) articulated a

significant need to better understand how nurses, as moral agents, are influenced by and influence the complex socio-political structures they inhabit. The findings in this study provide further understanding into the relationship of the individual and structure. Understanding the experience of moral distress in leaders illuminates how the phenomenon contributes to job dissatisfaction, attrition and retention, leadership response, and physical well-being (Barkouli, 2015; Corley, 2002; Erlen, 2001; Hamric, 2002; Nathaniel, 2006; Wilkinson, 1987). Furthermore, the ubiquitous nature of moral distress within the nursing leadership culture speaks to the relevancy and need for institutional attention on how to mitigate the experience and support the leaders. Even with the omnipresent nature of moral distress, there is hesitancy and vulnerability within the community to openly discuss the topic in daily practice due to a palpable fear and stigma linked to job security and future professional career opportunities.

Interpretation: relationships matter. One of the key findings of this study was identifying the pivotal role that multiple relationships have on navigating through and meaning-making of nurse leaders' moral distress. The relevancy of relationships was fundamental and crucial in coping, stress reduction, personal growth, and overall quality of life. As discussed by previous scholars (Rodney, Kadyschuk, et al., 2013; Varcoe et al., 2012a, 2012b), enactment of moral agency (i.e., a person who is capable of ethical deliberate action) was supported through relationship. This is consistent with my findings. Of the five types of relationships discussed by participants (supervisory, nurse-administrator-physician, peer, family/friend, and self), it was the supervisory relationship that was most integral to the experience of moral distress and the peer relationship that provided significant support for the leader during and after the experience. The majority of participants acknowledged the importance of a positive relationship with their supervisor, identifying characteristics such as

approachability, visibility, mentorship, trust, confidence, engagement, and collaboration/partnerships. These elements assisted in meaning making, providing support, and feeling relief. While there is some research on supportive dialogue with colleagues (Musto, 2010), this study illuminates aspects of dialogue with supervisors that were found to be supportive in working through the experience of moral distress. These aspects or actions included providing support (emotionally, physically, politically), guidance (what would they do), active listening, patience, and help when difficult situations were shared, by offering sympathy, expressing confidence in the leader's ability, and offering mentorship. It was evident from the participants' comments that a positive relationship fosters openness, trust, respect, support, and the creation of a safe place in order to discuss the challenges of ethical issues and the enactment of moral agency. The importance of having a safe place for nurses and providers to discuss ethical concerns in their practice was identified in the literature (Bell & Breslin, 2008; Storch, Rodney, et al., 2009a, 2009b; Zuzelo, 2007), which was consistent with the findings in this study.

As found by other researchers (Jakobsen & Sorlie, 2010; Varcoe, Pauly, et al., 2012; Zuzelo, 2007) the way supervisors responded to raised ethical concerns of employees was important in how the concerns were addressed and in how the supervisors influenced the actions and feelings of the employee. This, too, is consistent with the findings in this study where participants identified supervisor's behaviors that contributed to negative relationships that contributed to moral distress such as micro-management, lack of transparency, disregard for process, lack of nursing leadership presence, and leadership incompetence. Clearly, supervisors play an important role in contributing to the experience of moral distress, in either a positive or negative way.

The importance of family was another significant insight about relationships. Family provided a forum to discuss the situation and share the accompanying emotions that allowed participants to cope with the experience, interpret and make meaning, and offer an alternative/normative perspective to the experience.

Another finding was the strength and resilience participants found through knowing and understanding who they were as individuals, knowledge of self, which helped them navigate through and out of moral distress. I call this relationship to self. Many of the participants viewed this as a leadership competency and articulated this as being a key to their success as a leader. They shared how they referred to their personal ethical framework when they encountered morally difficult situations that helped them through the situation. Additionally, the importance of spirituality or having an awareness of one's' personal faith values was noted as either assisting or creating moral distress for leaders during ethically difficult situations. This aligns with McCarthy and Deady's (2008) assertion that moral distress can make individuals more aware of and reflective of their own moral, spiritual, and philosophical beliefs, thus strengthening their resolve for future events.

Looking down from Heifetz's balcony and reflecting on moral distress, what is clear to me is the importance of relational leadership for nursing leaders. As a nurse this is a natural extension to the leadership domain as nurses' work has always been "embedded in the interconnectedness and relationships of the structure of everyday health care encounters- sometimes to the detriment of the autonomy and integrity of nurses as moral agents" (Rodney, Kadyschuk, et al., 2013, p. 173). This can be true of moral distress as it applies to leadership. As relational leaders these nurses must be self-aware of who they are as individuals and professionals, recognizing their own and others' feelings (emotional intelligence), understanding

their own and others' values (which may be different) (ethical intelligence), and above all, having a strong capacity to engage, connect, and interact effectively and respectively with others (relational intelligence). These three elements: emotional, ethical, and relational intelligence support Pless and Maak's (2005) findings on relational leadership. Additionally, the presence of power dynamics and relationships in organizational environments were also identified in this study highlighting the importance and need of political intelligence as a leader, especially when ethically difficult situations occurred. It was evident from the participants' comments that nursing leaders need a variety of support systems to help them navigate during and through morally distressing situations. Fostering and encouraging strong relationships (professional and personal) in order to face the complexity of the health care environment and the myriad of ethical situations that occur within this environment is nothing short of vital. This was echoed in law enforcement and education literature as discussed in Chapter II. Simply put, leaders must be able to connect with people to avoid isolation that furthers the suffering of moral distress and impacts the individual's well-being.

Interpretation: navigating and emerging through moral distress. This is one of a few studies (Ganz et al., 2015; Gaudine & Beaton, 2002; Mitton et al., 2011; Nuttgens & Chang, 2013; Pauly et al., 2009; Porter, 2010) that further enhances our understanding of the meaning of moral distress through the experiential perspectives of nursing leaders. What was unique about this study is that the nurse leaders' personal strategies for navigating through moral distress are illuminated. The literature about how leaders navigate and emerge from moral distress is partial at best, but this study contributes by capturing strategies, lessons, and recommendations made by the participants (Figure 5.1). Reflecting on how the interpretation of these strategies, lessons, and recommendations help us understand the situation of nurse leaders, several thoughts emerge.

First, the strategies for navigating and emerging through moral distress involve passive and active processes. What was clear from the literature review on moral distress within nursing and other industries in Chapter II was a void in the discourse on solutions for moral distress for leaders. The findings of this study supported this dearth in resources and tools. Leaders utilized clinical judgment, informed by personal life and clinical experiences, values/beliefs, and professional standards. Various strategies were identified to aid in coping. These strategies were self-taught and organically refined with each new experience of moral distress. In addition, there was an underlying resourcefulness within the strategies that fostered further coping strategies during periods of moral distress. This highlights the autonomy and resilience currently required when confronted with ethically challenging situations as a leader in health care today. The strength and resilience appear to be garnered from knowing and understanding who one is as an individual and nursing leader.

Another interpretation garnered from the findings is the potentially isolating nature of the role of nursing leader during periods of moral distress due to the self-initiated autonomous process for resolution. Additionally, leaders must not only navigate themselves out of moral distress, but also those they lead. Multiple participants commented on the loneliness of the role, due to lack of access to a referent group, no support from HR, and lack of support from supervisors. Navigating the ethical whirlwind of moral distress is a tumultuous and confusing period of time where constraint in an enactment of moral agency can create fear or threats to leaders within the working environment. Rodney, Kadyschuk, et al. (2013) stated that for individuals to be effective moral agents, they must be present (in the here and now of the actual patient situation and trying to understand what their colleagues and/or patients are experiencing). Consequently, the importance for nursing leadership practice is leveraging support for leaders

through an organizational and personal response. The strategies and lessons shared in this study underscore the importance of social support systems and coalitions. Successful navigation and emergence from moral distress is grounded in the relationships leaders create, nurture, and maintain. When these support systems are perceived as inadequate or useless, moral distress generally occurs. It is important for institutions to gain insight into the complexity of the moral conflicts that are present in the health care system and the expertise and support required to assist leaders in negotiating them.

So, what is learned from how nurse leaders navigate moral distress and why is this important to leadership practice? The strategies/lessons/recommendations reveal that nursing leaders are proficient active reflective practitioners. Self-reflection allowed participants to focus on how they interacted and reacted with colleagues, the clinical situation, and the larger environment. It assisted the leaders in processing the morally distressing situation and allowed for added perspective, confidence, meaning-making, and assistance in decision-making. Dewey (1910) stated, “Successive portions of reflective thought grow out of one another and support one another” (p. 3), implying the creation of a foundation for further learning and reflection. The significance in this is that experiential and reflective learning are iterative processes. Learning builds and develops into further reflection and experience. This was revealed when participants shared their personal strategies for coping with moral distress and the subsequent lessons learned. Self-reflection led to continuous and applied learning to inform individual behavior and coping strategies. The relevance of experiential and reflective learning is seen in the resilience, resourcefulness, and self-awareness within nursing leaders. Through these characteristics, the participants were able to navigate and make meaning from their experiences of moral distress, creating not only personal transformation, but also passing on the understanding of the

experience to others going through similar experiences, thus providing professional mentorship. While situations of moral distress are unique in their own context, the importance of experiential and reflective learning is that it builds a repository on which leaders may draw from in future situations. Further research and policy on moral distress, regarding interventions specific to health care leaders, is important for institutions to understand, given the differences in work ethics and generational diversity.

Implications

The importance of moral distress to nursing practice has been widely acknowledged for decades within the scholarship body and the professional regulating bodies (American Association of Critical Care Nurses, 2006; Canadian Nurses Association, 2008; Kopala & Burkhart, 2005; NANDA International, 2003). While the focus of most of these studies has been on direct front-line nurses (Corley et al., 2001; Gutierrez, 2005; Hamric & Blackhall, 2007; Jameton, 1984, 1993; McCarthy & Deady, 2008; Pauly et al., 2009; Rice et al., 2008; Wilkinson, 1987), the experience of moral distress and its impact on practice among nurse leaders has been surprisingly elusive, apart from a handful of research studies (Edmonson, 2010; Gaudine & Beaton, 2002; Mitton et al., 2011). This current study contributes to filling this gap of impact on practice by illuminating the complex moral whirlwind experienced by nursing leaders when they are confronted with difficult ethical situations that constrain their enactment of moral agency. As I take one last look from Heifetz's balcony and observe the dance of moral distress within nursing leadership, I offer several implications (or the so what) framed as recommendations for real-world leadership practice, policy implications for institutional health care environments, and future research to diminish conditions that produce moral distress.

Recommendations for real-world leadership practice. The findings of this study cannot be generalized but should rather be seen as an added voice in the ongoing conversation about moral distress. My study's overarching objective was to bring the voices of nursing leaders to the forefront and create an opportunity to learn from their experiences. Drawing from this study, the following recommendations are suggested to promote the development of a positive quality of personal and professional life and assist in mitigating moral distress as it applies to nursing leaders.

Enhanced leadership education. Over the years nursing educators and leaders have consistently commented on the gap between real-world knowledge needed in clinical practice and the inferior preparation afforded by current nursing curricula (Canadian Nurse, 2013). This first suggested recommendation for action would be directed at graduate-level courses in nursing academia and within health care institutions. With each shared story of moral distress, the importance of education about emotional, relational, ethical, and political intelligence became apparent as one of the recommendations vital to assist nursing leaders in dealing with and mitigating moral distress. Participants confirmed that their organizations offered leadership development education; however, these were perceived to be unhelpful in the day-to-day issues that could create moral distress. The finding of this study would indicate that relevant and competency-based preparatory and continuing leadership education programs could be enhanced to support nursing leaders in the increasing complex work environment of health care. Key subject areas of study that could be considered to support leaders with the wide range of ethical issues and concerns encountered in their role include the following: (a) core business and financial principles and their application to delivery of health care; (b) practice-based leadership bioethics training, encompassing professional and business ethics; (c) enhanced communication

courses on conflict and negotiation; (d) ethical decision-making and knowledge of complex management of psychosocial challenges experienced by the population (i.e. isolation, poverty, abuse/neglect, mental health issues) and the support of integrated care teams to assist with the management of these cases; (e) emotional, ethical, relational, and political intelligence training to enhance optimal cognitive performance (i.e., biofeedback, case studies/forums, education on power roles and hierarchy); and (f) moral distress as an entity of its own. Employees, professional bodies, and institutions hold an expectation of leaders to resolve and prevent moral distress in the clinical work environment. As such, it would be beneficial to ensure that all health care leaders (especially at the top of the hierarchy and within government) are well-skilled and informed about moral distress, specifically in how they contribute to it, how they can solve it, and how it exists for them, so the real knowledge, awareness, acceptance, and mitigation of this phenomenon can occur.

Organizational investment in creating relational and safe support systems for leaders. The importance of relationship was a central observation woven through the findings of this study. Participants found the job very lonely and believed nursing leaders' work was inherently isolating**.** This isolation could be the consequence of not having a referent group easily available, lacking supervisor support, or being new to the organization. One recommendation for consideration is for institutions to invest in the creation of safe and respectful environments where relational support systems can flourish. Strategies for creating these support systems include designing formal mentorship programs for leaders that intentionally foster formal /informal buddy systems. While every participant did not have mentors, they all valued relationships with mentors, and most reported these relationships were formed informally through interactions with other leaders or previous supervisors. Mentorship programs contribute

to healthy organizational cultures as they provide opportunities for continued learning, create supportive relationships, foster value as a practicing professional throughout the organization, provide opportunities for increased confidence, augment decision-making, and enhance job satisfaction (Apker, Ford, & Fox, 2003; Jakubik et al., 2004; Neuhauser, 2002; Newhouse & Mills, 2002).

Other strategies for consideration include the consistent use of executive coaches (individually) and organizational/development consultants (within leadership teams) to support leaders as they navigate the complex issues within their portfolios. Cognizant of the fear and stigma of moral distress and the perception of being viewed as being incompetent or unable to cope, these resources would need to operate on a confidential, no blame agenda geared to supporting the leader. Organizations might consider establishing a push-versus-pull model composed of resources that are visible and available for leaders who work in under-resourced over-worked environments. Integrating these resources into leadership teams would create a culture of acceptance, trust, and support. Additionally, fun, interactive personal development and team building activities such as escape room game experiences or outdoor obstacle courses may nurture trust, relationship, collaboration, and group initiative. Another suggestion to build relationship is to set time aside for lunch with colleagues to discuss opportunities and challenges encountered during the day versus eating alone at one's desk.

Institutions could also create regular institution-wide networking opportunities through semi-annual leadership professional days where executive leadership could interact with leaders about strategic planning; it would be advantageous to supplement these professional days with leadership seminars on current leadership issues and trends. Such seminars may provide an opportunity for leaders to build relationships that are vital in forming support systems that could

aid in the delivery of patient care and also provide support to leaders in their practice. The extension of relational support systems might also be considered outside of the organization at provincial and federal levels; whereby, support systems are fostered to help navigate health care issues across the country and provide support for leaders as they encounter and address constraints within the health care system.

Manageable workload and span of control. The third suggested recommendation to mitigate moral distress within the leadership role is for institutions to review leaders' span of control and workload. Overall, within the health care system, nurses at all levels are working harder, caring for more individuals, and spending less time with each patient. The same is true for nursing leaders. In this study, the expansive span of control and the concomitant need to continuously rush to catch up, leaves important work undone, adding complexity and moral distress to nursing leader's role. These findings are reinforced in stress and coping literature related to the nurse manager role (Shirey et al., 2008; Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010). At present, there is no way to quantitatively capture the workload or moral distress reported by leaders. That said, institutions might consider creating a venue in their on-line safety learning systems to document workload and moral distress experiences. Recognizing the fear and stigma present within the leadership culture regarding disclosure of moral distress, this venue would need to cultivate a culture of support and safety in reporting. The information captured through a tool like this would allow further study on moral distress by identifying and quantifying acuity of experience, complexity variables of the work and the clinical environment, patterns contributing to the experience, capacity of leaders, and building an organizational culture of acknowledging the presence of moral distress and its impact on well-being.

Relevant leader-focused resources. Many of the traditional organizational supports that leaders have accessed in the past are not keeping pace with the current need to navigate the complexity of ethical situations that are occurring within the clinical environment, specifically as it relates to human resources, employee engagement supports, and ethics. Health care is a 24-hour operation that is in constant motion, demanding immediate attention and an ability of leaders to juggle multiple complex issues at the same time. At present, within the health authorities sampled across Canada, access to these resources is on a fixed business schedule with no availability after-hours or weekends. The reality of the health care environment is the need for reinforced organizational support systems and structure for nursing leaders. As a result of the findings of this study, institutions might want to review processes and procedures that dictate access to these resources. Additionally, consultants within these areas of practice must also be responsive and competent and have the critical insight into the informative guidance required to assist leaders in their decision-making. Ultimately, organizations could create a push-versus-pull model of support for leaders that is responsive and supportive to leaders that meet their needs.

One recommendation mirrors a powerful strategy currently used in many emergency departments across Canada to avoid admissions to hospital: a Quick Response Team. This is an interdisciplinary team that responds to the emergent needs of patient care and can expedite safe discharges home. Establishing a quick response team comprised of a small team of inter-professionals could potentially be supportive of leaders during periods of ethically challenging clinical situations and moral distress; it might also help mitigate moral distress by creating a supportive culture within the organization for leaders (e.g., HR, Ethics Committee Member, Client Relations/Risk Management Consultant and Executive Leader). Such a resource

could be available 24-hours per day/seven days a week; it will also be important that a safe culture is in place for accessing this mechanism.

Transparency in large-scale organizational change. This study afforded the unique opportunity to explore the relationship between moral distress and large-scale organizational change (leadership reorganization) that was occurring in two organizations. Perceived supervisors' disregard for core organizational process and values triggered moral distress. Enhancing and maintaining transparency, communication, fair hiring practices, and adherence to ethical strategies to assist with the large-scale organizational change during institutional reorganizations is vital. Modeling these behaviors could potentially be critical to the success of the change, morale of the institution, and mitigation of elements that give rise to moral distress for nursing leaders.

Additionally, in response to this study's findings, the importance of risk analysis in large-scale organization change is recommended. Study data indicated that executive leaders overseeing these changes might benefit by acknowledging the potential impact of moral distress, not only on front-line providers and organizational operations, but also on nurse leaders. Risk responses can be anticipated and planned for when new initiatives are implemented that may create moral distress. The implementation of a risk analysis approach could benefit the organization, shifting its culture from an unplanned reactive responsive one to one with a proactive action plan, a shift that could potentially decrease the negative impacts of change on the individuals and the organization.

Organizational supportive work-life culture. Researchers have articulated that health care providers have difficulty in meeting the needs of their patients if their own needs are not met (Bhatnagar & Srivastava, 2012). Additionally, new workplace practices, rapid technological

advances, and tight institutional deadlines are creating work environments that are becoming less flexible; leaders are challenged by unrealistic expectations and increased stress. In this study, participants reported intense organizational expectations of constant and immediate response time, long work hours, and, in some cases, lower pay than that of their employees. To support a positive quality of work-life balance for nursing leaders, institutions could consider pro-actively investing in work-life strategies that enhance job satisfaction, and foster retention and overall well-being of those leading the health care system. Recommendations for consideration include the following: (a) implementing an institution-wide 24-48 hour email pause (with criteria for urgent/critical process contingency plans) weekly or monthly to create space for completion of work, (b) ensuring fair compensation based on complexity and responsibility of role and correcting wage disparities between leaders and employees, (c) investing in processes and systems to support leader's non-working hours (i.e., modifying expectations to attend meetings and immediately respond to emails while on vacation), (d) accessing leadership workload resources, and (e) limiting business meetings hours (e.g., 0800–1100) to create space for direct clinical engagement with front-line staff in clinical areas, thus fostering enhanced quality of care, leadership, and engagement of employees.

Nursing leaders are passionate about their roles and reflective experiential learners. Recommendations to continue to fuel their quest for knowledge include institutional support for learning expeditions for leaders to visit best-practice/magnet institutions that will stimulate learning, advance institutional knowledge, and build resiliency in leaders. Another recommendation is to provide tuition reimbursement (or paid time off) for graduate/post graduate academic pursuits or conferences. One final recommendation for institutions is to consider ways to support and foster neutral peer relationships/ networks (within or outside of health care

industry) where nursing leaders have the opportunity to create safe spaces to discuss difficult ethical situations, debrief, gather support, and problem solve.

Recommendations for institutional and government policy. Adding to the implications for clinical practice and future research, the findings from this present study have implications for institutional and government policy. The analysis of these data suggests that institutions and governments might benefit from further understanding the role complexities of their nurse leaders and explore how the organizations or system as a whole contributes to employee and leader moral distress. In addition, organizations could consider approaches to creating and sustaining healthy work environments that support employees and acknowledge their contributions. The following policy recommendations are suggested for institutional health care environments to diminish conditions that increase the likelihood of moral distress.

Moral distress policy. Considering the professional and organizational expectation of nursing leaders to resolve and mitigate moral distress in the health care environment, institutions (meso) and provincial/federal policy makers in government (macro) could be well served to learn more about the current complexities of the internal and external tensions experienced by nursing leaders (and other health providers) and the relationship of these tensions to moral agency, constraints in agency, and the well-being of individuals (patients, employees, and leaders) in the health care system. This policy could include a standardized organizational process, available tools and resources, and reporting mechanisms.

Nurses as senior health care leaders. Nursing leaders play an integral role in the immediate lives of nurses and within the entire health care environment. They create, keep, and are the recipients of the nursing culture of the organization in which they practice (Edmonson, 2010). As such, an organizational policy with a formal mechanism for ensuring that current

clinically competent nursing leaders are present within all levels of leadership could be beneficial. Having chief nursing officers or nursing leaders within senior echelons of the ministry, health care organizations and front-lines of acute and community care areas is also important. These nursing leaders are critical to support high-quality professional practice and assist nurses in feeling safe in the delivery of safe patient care. Participants felt that nurses are not as visible as they should be at the senior decision-making tables within their organizations. While there are many sources of stress in health care environments, moral distress has been identified as a significant concern due to the ethical dimensions of clinical practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties (Epstein &Hamric, 2009; Herdman, 2004; Kälvemark et al., 2004; Sporrong et al., 2006). Increasing the presence of nursing leaders within leadership positions and in governments across the province will help provide the lens and forum through which moral distress is perceived and viewed.

Public education on new expectations in health care delivery and support of leaders enacting change. As the delivery of health services across Canada shifts from a disease and acute care system to one focused on primary and community resources, there is a need for developing a strategic policy to maintain and expand acute care services due to an aging infrastructure and population demands and pressures currently taxing services. Several of these pressures and the link to moral distress were highlighted in Chapter IV. For example, additional inpatient capacity is and will continue to be required due to an aging population, co-morbidities, and acuity. What is needed is a balance of services and resources in acute care and community resources to meet the needs of the future. Picard (2013) stated, “We need a health care system designed to deliver chronic care to an aging population. The ‘journey of care’ does not last a few

days anymore, it often lasts years" (p. 147). With this in mind, and the shift in cultures advocated by government, further policy and public education could be considered regarding new expectations of health care delivery—specifically the shift to primary care and family expectation in providing care. The strategies and priorities with this policy will require thoughtful analysis of how to change public culture and shift care back to families and community, specifically to those vulnerable populations like the elderly or mental health populations where complex psychosocial elements are constraining (e.g., limited/resistant family support and housing, financial, and safety issues).

A further strategy required with this policy is for institutions and governments to support leaders in navigating emerging changes (and culture) required for the strategic shift from acute to primary and community care. Specifically, it would be beneficial to nurture a no-blame philosophy when organizations or governments receive complaints from the public or threats to "go to the media" regarding patient/family expectations of care that do not meet organizational expectations. Many participants shared how threats of media reports or complaints to the ministry created significant moral distress for leaders, especially when there was no avenue of support from within the organization. The morally distressing elements for these leaders when patient care experiences became community-wide discussions included observing staff suffer under the weight of unfair accusations, media biases, and the inability to defend staff when the organization's actions had adhered to standard protocol. The other element participants acknowledged was the significant pressure from local governments and the organization to diffuse such issues. Findings of this study suggested the potential for improved delivery of services when institutions and governments were not reactive to public opinion but, instead,

focused their attentions on working together with nursing leaders to ensure best practice standards of care delivery.

Enactment of respectful workplace and anti-bullying policies. Multiple participants described an oppressive leadership culture within which incivility or discrimination occurred. While many organizations have respectful workplace and anti-bullying policies in place, several participants articulated that these behaviors are present in the leadership culture. Regular performance evaluations, inclusive of these specific policies, that consolidate feedback from multiple sources about senior leaders' behavior could be beneficial.

Pro-active leadership forums. Holding frequent local, provincial and national forums for shared learning, planning, and responding to significant societal events that impact the health care system could also help. Over the last decade, nursing leaders have acquired significant experience and organizational history of the impact on health care through events like natural disasters (Fort McMurray, Alberta fire), national economic recession (oil recession), and global pandemics (SARS and Ebola). They have had to establish and enact large-scale evacuation plans, manage surges of mental health patients with restricted resources (Alberta oil recession), and create in-the-moment infection control strategies to protect patients, employees, and the public from global pandemics. Pro-active leadership forums could create a venue for building a repository of policies and processes that could serve as resources as needed. Nursing leadership should be included in these forums, so when future events occur, those who lead it are prepared with solid strategies to navigate through difficult times.

Recommendations for future research. This study opens up paths for future research on moral distress. Continued qualitative or interpretive research could be designed to further understand the experiences of moral distress from the perspective of *all levels* of current leaders

in health care within organizations—from the CEO level to front-line leaders supporting and providing direct care to patients. Such research might consider including pre-existing data sets or secondary analysis so historical context is illuminated and future researchers can build on the primary analysis of past researchers. The expansion of this research might consider including multiple organizations, other countries, national experiences, and the support systems identified as vital for nursing leaders to navigate moral distress. Including the perspectives of family members and colleagues and the strategies they use to support them could provide further insight into the leadership experience of moral distress across cultures and allow for a deeper examination of the personal impact of moral distress on leaders. This analysis could lead to other insights about resiliency and organizational strategies that are beneficial in mitigating moral distress.

One of the observations I noted in this study was how the known and unknown researcher influences the participants' disclosure of the experience of moral distress. Further research into this observation, as well as dyadic relationships between leaders, followers, and even family members would be interesting to explore to add further meaning to the phenomenon as it relates to leaders.

While this specific study indirectly highlighted the perceived diversity of experience among leadership levels, additional study could further illuminate the phenomenon through a leadership lens. Specifically, a mixed method study could use a Moral Distress Scale or a critical incident technique in conjunction with qualitative inquiry to measure frequency and intensity of moral distress, gather further qualitative narrative of the experience and perception of experiences of moral distress, and explore other related factors that may contribute to moral distress such as fear, incivility, and workplace violence. A further suggestion, using a mixed

method design, would be to conduct an interventional study to examine the merits and impact of the intervention on the intensity, frequency, and diminishment of moral distress within an organization and its leaders. This is especially critical as the nursing workforce is aging, and organizations will need to adapt to the changing generational demands for positive life-work balance.

A final suggestion for future research to enhance our understanding of moral distress as an embodied experience is to conduct prospective and real-time longitudinal qualitative studies on the effect of and strategies/lessons learned during moral distress through a leadership lens. This may help extract an expanded insight into neural growth and the relationship between the agent and structure.

Figure 5.1 provides a visual summary of the overarching interpretations gathered from the study's participants related to the strategies they utilized in clinical practice, some of the lessons learned through moral distress as a nurse and leader, recommendations and several implications from this study framed as recommendations for consideration for real world leadership practice, policy implications for institutional health care environments, and future research on moral distress from a leadership context.

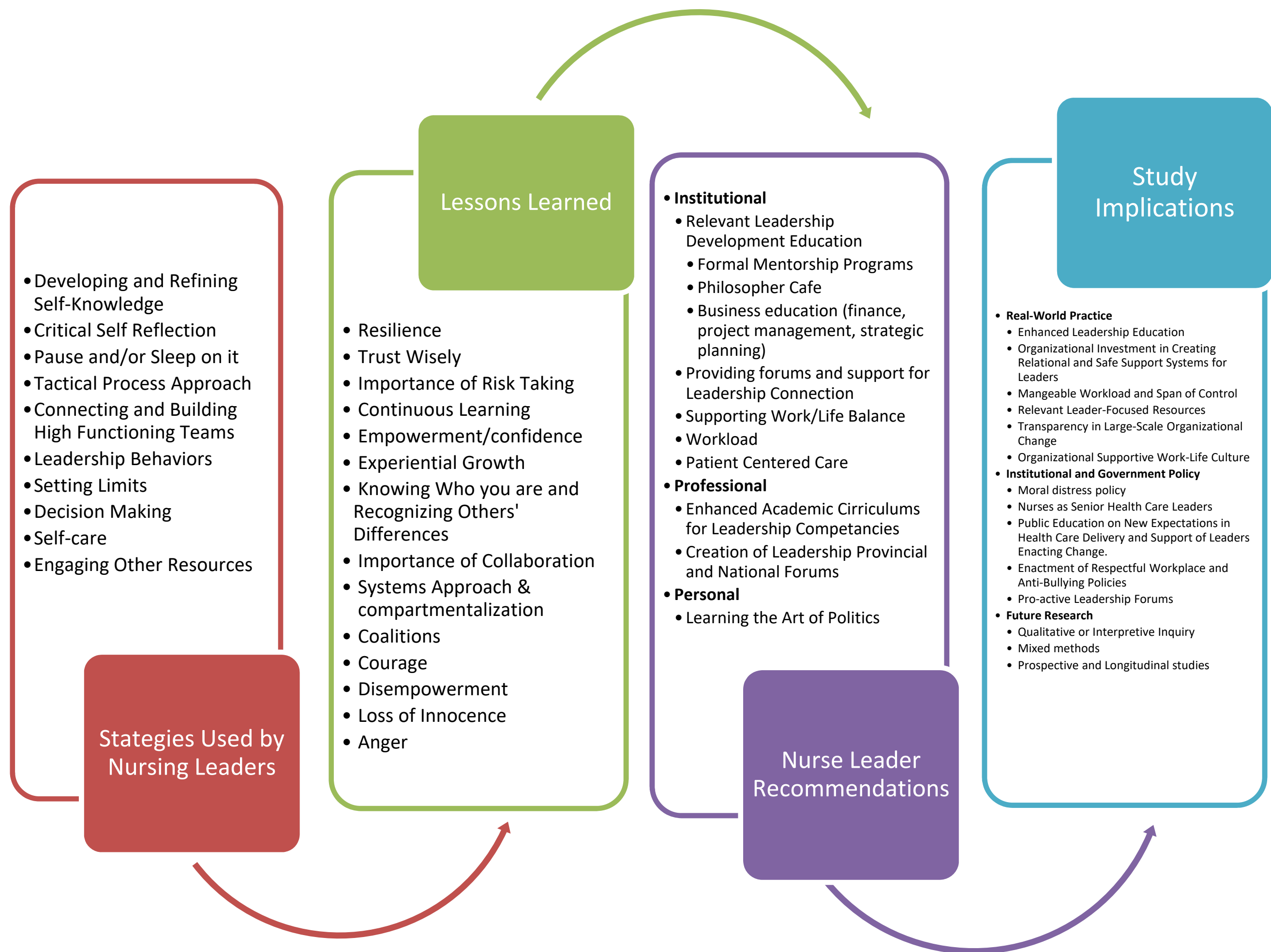

Figure 5.1 Summary of nursing leaders strategies, lessons, recommendations and study implications.

Limitations of the Study

This study demonstrated delimitations and limitations consistent with qualitative research. The scope of this study included 32 nursing leaders with recent or current experience working in various acute care hospital settings across Canada. One of the first delimitations is in the sampling approach. Participants were primarily sampled and recruited by convenience and purposeful sampling of individuals with direct knowledge of the phenomenon under inquiry. In this case, the sample consisted primarily of managers and directors with a small sample of senior nursing executives. In addition, over half of the sample was leaders in emergency or critical care

areas; this was predominantly due to the researcher's personal networks. Further, this sample was delimited to the professional body of nurses and did not seek the perspectives of other health care leaders within acute care as well as across the continuum of care; however, one senior leader held dual responsibilities within her organization for acute care and community. One of the limitations experienced with purposeful sampling, specifically outside of the province of British Columbia, was organizational ethical board approval and/or senior executive approval to participate in the study. The sample size of 32 was decided upon as data saturation was realized: no new information concerning the phenomenon emerged during the iterative process of data collection and analysis as in-depth and comprehensive descriptions of how participants varied in their experience and perspectives was obtained.

Delimitation was also found in the research design, specifically in the process of data collection. Only three data sources were utilized: the interviews with the participants, field notes, and journaling. In Chapter III it was articulated that at the end of data collection, a sub-set of participants would be selected for a focus group to reveal further themes. This technique was not pursued when interviews began to reveal the emotions, vulnerability, and professional risk involved for participants, as well as clear saturation of information.

Finally, as a neophyte qualitative researcher, I recognize that my limited experience with data collection, interpretation, and analysis influenced the findings of this study. Researchers with more expertise in the iterative process of ID may have garnered deeper understanding and contextual information from the stories shared, producing different findings and understandings of the phenomenon of moral distress in nursing leaders.

Evaluation of credibility. Every effort was made to meet the four principles that guide the evaluation of credibility in an ID study:

- Epistemological integrity was met by outlining the tenets of ID through (a) the critical review of the literature in Chapter II; (b) my discussion of my theoretical, professional, methodological, and personal assumptions which may have influenced my research in Chapter III; and (c) keeping all of these in mind as decisions about data collection, analysis and interpretation were made.
- Qualitative research credibility was sought by sampling selection and through a checks and balances process (member check) by faculty advisors and peer consultants.
- Analytic logic was accomplished through keeping an audit trail of coding themes, outlining my cognitive reasoning and research decisions, ensuring transparency and consistency in the research process supplemented through analytical discussions with faculty.
- Interpretive authority was achieved through triangulation of data sources (i.e., person-to-person interviews, field notes, discussion with faculty/ peer colleagues, and reflective journaling), and the iterative process of constant comparison between interviews throughout the data collection and analysis process.

This study conveys what these participants recall from their experience and reflects their perceptions of moral distress; however, the general population of nurse leaders might reveal different values, beliefs, and experiences. Regardless, the study afforded the opportunity to explore the ontological experience of moral distress through a nursing leadership lens, thus providing additional contextual understanding within the practice domain.

Positionality

As a registered nurse and senior nursing leader (director of emergency, critical care and medicine services) in an acute care hospital within Canada, my views on leadership are grounded by four pillars: my professional practice standards, personal values, relationships, and academic theory. With a responsibility to provide overall leadership and direction for operational staff that supports and adheres to patient safety and regulatory and professional standards, I utilize evidenced-based practice on a daily basis. As such, I approached this study as a practitioner-researcher. With an array of methodological inquiry options available to guide my study, I purposely chose a qualitative method of inquiry derived from nursing epistemology, ID, that borrows the best techniques from conventional qualitative approaches without taking on the full weight of the theoretical baggage of rigid and unbendable rules (Thorne, 2008). I wanted a methodological strategy for excavating and illuminating knowledge that is found between fact and conjecture and guided by disciplinary orientation, thus allowing application to the practice domain and answering the ever present proverbial nursing question of "so what."

When I began my doctoral journey, I had no vision of what topic I wanted to explore. What I brought was a deeply seated interest that I held as a nursing leader in exploring how those in my profession navigate the incredibly complex, emotional, and political terrain of the health care environment. In essence, I wanted to learn what the secret of leadership entailed and, more importantly, find the little black book with all of the answers in it. As I progressed through my doctoral studies, examining a variety of challenging topics in health care, I kept returning to a phenomenon where ethics and constraints in moral action surfaced. This phenomenon became the focus for this study, and as I reflect now, was the perfect inquiry into a leadership practice issue worthy of exploration and application within the practice domain.

My positionality informed my interest in this study and how I chose to study the phenomenon. I was very sensitive to the explicit personal location of myself, not only as a nursing leader who has experienced the phenomena, but also as a researcher within the context of the question that was the basis for this study. The concern that I was vividly aware of is that personal experience shapes understanding (Thorne, 2008). I freely admit that walking the line between researcher and nursing leader within this study was challenging as I could and did strongly empathize with the participants and the experiences they had shared. To mitigate bias, I made a conscious effort to remain as objective as possible. One strategy that I used was self-reflexivity and transparency through the research process. I was purposefully reflective at all times while interacting with participants and resulting data to maintain objectivity and report on the perspectives of the participants—not my own personal perspectives. I found the assistance of a semi-structured interview tool very helpful as the opening questions set the context of the discussion and participants engaged in dialogue that was important to them. As a researcher I followed their lead, allowing me to step into their world of knowing. The identified themes are, therefore, grounded firmly in the voices of each participant. Other strategies included active listening, avoidance of filling in blanks to their stories, and using probing questions and paraphrasing to garner the participants' meaning of experience.

Polit and Beck (2012) assert that bias can influence or distort study results, specifically researcher subjectivity. While acknowledging that a professional allegiance can create drawbacks, I do believe that my role as a nursing leader facilitated the recruitment of participants and the depth of disclosure that was obtained in this study. This conclusion was made during my recruitment process where securing participants outside of the province of British Columbia was very difficult with many potential participants citing requirements of organizational or senior

leadership support. An observation that I noted in my journal was the difference in interviews with those whom I did not know professionally. All of these interviews began very guardedly, possibly due to the vulnerability, trust, and confidentiality of the experiences. I realized that if I disclosed my professional background, along with my interest in my research question as a learner, my transparency would facilitate dialogue and, more importantly, build the researcher-participant relationship.

As a nurse, one of the underlying ethical principles that I live by is to do no harm. This holds true to the role of researcher. I quickly discovered after conducting my second interview that participants could express residual emotion during and from their discussion of their past experiences. These expressions of emotions were through physical action, tone of voice, verbalization, crying, and flushing. For those who expressed these intense feelings, the interviews were stopped, and participants were asked if they wanted to continue. All agreed to continue and verbalized that having an opportunity to discuss the situation that occurred, even months or years in the past, allowed them to validate the experience and brought a sense of relief to them. These participants were all followed up with a phone call by the researcher; all reported no harm.

As I reflect on this doctoral journey and the early days of conceptualizing this research and reviewing earlier topics on the challenges within health care that led to my candidacy, I am humbled by the personal and professional self-growth this journey has afforded me. When I started this journey, I held a deep curiosity and desire to find the secret that other leaders appeared to know regarding the navigation of incredibly complex ethical situations in health care, especially since it appeared to me that these leaders had emerged untouched or unafraid. As a nurse and leader, I had experienced multiple situations where cognitive dissonance and

confusion occurred over knowing the right moral course of action to take but being constrained to act on the issue due to some limitation in the system. By conducting this study, I had the exquisite opportunity and privilege to spend time talking with 32 inspirational nursing leaders across Canada. Each embodied profound commitment, passion, dedication, selflessness, and tenacity as a nurse and nursing leader. I was humbled by the incredible support they gave me by agreeing to participate (to help me achieve a personal academic goal). They blocked out times in their busy schedules, and the personal disclosure and vulnerability, along with accompanying emotions and feelings, that they shared added depth and integrity to the findings. Quite honestly, I did not expect this depth of experience shared and, at times, was overwhelmed with the experiences many of these individuals had endured in their leadership careers. This was a gift that I not only treasured, but also felt as a huge weight of responsibility. I walk away with a new appreciation for the excruciatingly hard work and enormity of translating all of the valuable insights shared with me about nursing leaders' moral distress to fully ensure that the participants' experiences and voices are shared. The weight of experiences shared and the safeguard of my participants' confidentiality quickly became apparent to me, providing me with a greater understanding that the full stories and their accompanying emotions and feelings of moral distress may never be disclosed within the literature due to the need for the confidentiality of patient information as well as the protection of the research participants.

Finally, the process of conducting original research and writing about such an important and relevant topic was not only an exquisite privilege, but also a humbling one. The participants in this study graciously shared their experiences of moral distress as nursing leaders that revealed vulnerability at a personal and professional level. I was afforded a rare opportunity to dialogue about their experiences, emotions, feelings, values, and lessons. My motivation for studying this

topic arose from curiosity in how I could learn to be a better leader during difficult ethical situations. As I began the collection of data, I quickly realized my curiosity in this topic was not isolated. Participants expressed a desire to learn more about the phenomenon and, more importantly, requested information on how to navigate successfully through moral distress. Within my own practice this became more evident to me when I was recently approached by two new leaders on separate occasions who were experiencing moral distress. The essence of their questions mirrored mine (What is the secret? Where is the little black book with all of the answers? How does one navigate moral distress?). The relevance and importance of this research became more apparent to me at that moment.

Conclusions

Moral distress has been the subject of intense research over the last three decades, specifically within the health care industry and, in particular, the profession of nursing. While there has been an abundance of research on the impact and experience of moral distress on front-line nurses, there has been scant information on those who lead nurses, nursing leaders. Moral distress is a serious consequence of constrained moral agency and has become increasingly identified in the literature as a patient safety concern, as well as an employee and leadership issue: an issue commanding organizational attention.

This interpretive descriptive study represents a further step in understanding the experiences and perceptions of moral distress through a leadership lens and brings the experiential perspectives and ways of knowing to the literature. It adds to our evolving knowledge of moral distress by contextualizing what the experience is like and what it means for nursing leaders. What is exciting about this study is that the voices of nursing leaders are illuminated. Their personal strategies of navigating through moral distress, the key lessons they

have learned from the experience, and, finally, the recommendations they suggested to mitigate the experience of moral distress have now been captured within the scholarship body. To date, there has been no other study found that provides this unique context that enhances the understanding of moral distress through a leadership lens. The findings from this study underscore the relevance of moral distress within the health care environment and illuminate the complex moral whirlwind experienced by nursing leaders when they are confronted with difficult ethical situations that constrain their enactment of moral agency. I look forward to further research on health care leader’s experience of moral distress and the development of new knowledge to further support those who are leading the health care system.

Appendix

Appendix A: Recruitment Invitation to Participate Email

Subject: Notice of Research Study: Moral Distress and Nursing Leaders
Sent : Jodi-rae Kortje

Dear Colleague

My name is Jodi-rae Kortje. I am a doctoral student in Leadership and Change at Antioch University. I am currently completing research for my dissertation on how nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian Health Care system. My credentials with Antioch University can be established by contacting Dr. Philomena Essed, Chair of the Antioch University Ph.D. in Leadership and Change IRB.

I am inviting you to participate in an interview and possible follow-up focus group. Your name was chosen as a prospective participant because of your leadership position. The purpose of this study is to gain a deeper understanding of moral distress from a leadership lens. It is hoped the study's results will identify approaches and resources that will mitigate the experience of moral distress and inform real-world clinical practice, leadership, organizations, and policy makers.

Information will be recorded in handwritten and audio-recorded format and, where appropriate summarized, in an anonymous format, in the body of the final dissertation. At no time will any specific comments be attributed to any individual unless your specific agreement has been obtained beforehand. All documentation will be kept strictly confidential.

This study has been approved by Fraser Health Authority Research Ethics Board (study identification #) and Antioch University Institutional Review Board (study identification #).

You are not required to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

If you would like to participate in my research project, please contact me either by email or telephone.

Warm Regards,

Jodi-rae Kortje BA, BSN, ENC, MSN

Appendix B: Formal Invitation to Participate in the Person-to-Person Interview and Focus Group

Canadian Nurse Leaders' Experiences with and Perceptions of Moral Distress: An Interpretive Descriptive Study

Principal Investigator: **Jodi-rae Kortje, BA, BSN, ENC, MSN**
Doctoral Student, Ph.D. in Leadership and Change, Antioch University

Sponsor: **Martha Cloutier**
Program Director Emergency Services, Fraser Health

Dear Participant,

You are formally invited to participate in this research study because you are a Registered Nurse (RN) and Nurse leader within the Canadian health care system.

In partial fulfillment of the requirement for a Doctoral Degree in Leadership and Change at Antioch University, I, Jodi-rae Kortje, (the Researcher), will be conducting a qualitative research study. My research will be exploring "*How health care nurse leaders make sense of their experiences with, perceptions of, and navigation through morally troubling situations within the Canadian Health Care System?* My credentials with Fraser Health Authority can be established by calling Martha Cloutier, Director of Emergency Programs. My credentials at Antioch University can be established by contacting Dr. Philomena Essed, Chair of the Antioch University Ph.D. in Leadership and Change IRB.

The purpose of this interpretive descriptive study is to understand the experiences and perceptions of moral distress within nurse leaders within the Canadian health care system with the aim of identifying approaches and resources that will mitigate the experience of moral distress and inform real-world clinical practice, leadership, organizations, and policy makers. This study will:

- Explore the experiences and perspectives of nurse leaders and moral distress.
- Uncover and describe themes and patterns specific to moral distress within leaders
- Explore key characteristics and impacts of moral distress on nurse leaders.
- Describe the internal and external factors that inform leaders' navigation through moral distress.
- Develop recommendations from nurse leaders regarding mitigation strategies for moral distress that promote the development of positive quality of life for leaders and nursing retention.

You are invited to participate in this research study because of your leadership experience within an acute care Canadian hospital. The study will involve an individual interview and a possible focus group. All interview questions will explore the participants' experiences with and perceptions of moral distress within their role as a nurse leader. Your participation is voluntary: you are not required to answer any questions you are not comfortable answering.

The person-to-person interviews will be held either in person in a mutually agreed upon location or via telephone/Skype. The interview is anticipated to last no longer than two hours. Each participant will be asked a number of open or closed-ended questions. Information will be recorded in hand-written form **as well as audio recordings** and will be summarized in an anonymous format in the body of the final report. You may be asked to participate in a focus group at Delta Hospital. The focus group will be a forum to further the discussion on moral distress within leaders and to confirm evolving conceptualization of research findings to ensure validity of the experiential perspective of moral distress in nursing leaders.

At no time will any specific comments be attributed to any individual unless your specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. Information collected will be kept securely in a locked cabinet and destroyed upon completion of the project.

You are not compelled to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

If you have any questions about this research study, please do not hesitate to contact me.

Sincerely,

Jodi-rae Kortje BA, BSN, ENC, MSN
Principal Investigator

Appendix C: Consent to Participate in the Person-to-Person Interview and Focus Group

Canadian Nurse Leaders' Experiences with and Perceptions of Moral Distress: An Interpretive Descriptive Study

Principal Investigator: **Jodi-rae Kortje, BA, BSN, ENC, MSN**
Doctoral Student, Ph.D. in Leadership and Change, Antioch University
Sponsor: **Martha Cloutier**
Program Director Emergency Services, Fraser Health

INTRODUCTION

I would like to invite you to be part of a research project that I am conducting. You are being invited to take part in this research study because of your leadership role in the Fraser Health Authority or other Canadian health authority within acute care as either a Manager, Director, Executive Director, or Vice President of nursing services.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Your participation will not have an effect on current or future employment. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen during the study and the possible benefits and risks.

If you wish to participate, you will be asked to sign this form. If you decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you choose not to participate or to withdraw from the study, this information will be maintained in confidence.

If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will it affect your employment.

Please take time to read the following information carefully.

WHO IS CONDUCTING THE STUDY?

My name is Jodi-rae Kortje and I am the Health Services Manager for the Emergency Department (ED) of Peace Arch and Delta Hospitals. This research project is part of the requirement for a Doctoral Degree in Leadership and Change at Antioch University. My credentials with Fraser Health Authority can be established by Martha Cloutier, Program Director Emergency Services. Credentials at Antioch University can be established by contacting Dr. Philomena Essed, Chair of the Antioch University Ph.D. in Leadership and Change IRB.

During this research study, I will be acting as both researcher and Health Services Manager in the Emergency Department at Peace Arch and Delta Hospitals. This represents a potential perceived conflict of interest. My intent is that while involved in this study my role will be that of impartial facilitator and researcher and not as the Health Services Manager in the Emergency Department at Peace Arch and Delta Hospitals.

BACKGROUND

The importance of moral distress to nursing practice has been widely acknowledged and discussed in the academic literature and within professional nursing bodies. The impact of this phenomenon has been thoroughly explored as it *specifically* relates to the frontline health care professional (i.e. nurse), the patient, and organization. What is absent in the literature is the firsthand perspective and *voice* of leaders' experiences of moral distress and how they make sense of ethical situations which underscores the significance of this study. The clinical reality of contemporary nurse leaders is that they are very involved in the clinical daily practice operations of health care as well as the administrative domain and responsibilities. The significance of this research is to provide further insight and understanding of the concept of moral distress from a leadership context. For leaders to flourish in the complexity of health care today, further nursing research on moral distress is needed from this leadership perspective so that policy makers, organization, researchers, and the professional nursing bodies can pause and really listen to the experiences and constraints of real contemporary ethically situations nurse leaders encounter.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this interpretive descriptive study is to understand the experiences and perceptions of moral distress within nurse leaders within the Canadian health care system with the aim of identifying approaches and resources that will mitigate the experience of moral distress and inform real-world clinical practice, leadership, and organizations, and policymakers. This study will:

- Explore the experiences and perspectives of nurse leaders and moral distress.
- Uncover and describe themes and patterns specific to moral distress within leaders
- Explore key characteristics and impacts of moral distress on nurse leaders.
- Describe the internal and external factors that inform leaders' navigation through moral distress.
- Develop recommendations from nurse leaders regarding mitigation strategies for moral distress that promote the development of positive quality of life for leaders and nursing retention.

WHO CAN PARTICIPATE IN THE STUDY?

Participants eligible to participate in this study must be:

1) Registered nurses;
2) A nurse leader within an acute care hospital in Canada overseeing at least one acute care program(s)/department(s) (i.e. emergency, critical care, medicine, surgery, obstetrics)

3) work within an organizational structure within a hospital setting in Canada with 3 or more levels of management (CEO, Vice President, Executive Director, Director, Manager);
4) Working full time within the nurse leader role for a minimum of 6 months;
5) Span of control of 25 employees' or more;
6) Fluent in English;
7) Willing to talk about and reflect on their experiences of moral distress.

WHO SHOULD NOT PARTICIPATE IN THE STUDY?

Any person who does not meet the inclusion criteria will not be eligible to participate in this study.

WHAT DOES THE STUDY INVOLVE?

You are being invited to participate in a person-to-person interview with myself as the researcher. Should you choose to participate, this study may involve two phases. Phase 1 will be conducted as a Person-to-Person Interview. Some participants may be invited for a second phase that will be conducted as a Focus Group where further research questions will be asked and conceptual findings from the study will be validated. Group size will be approximately 3-6 participants per focus group.

Phase 1: Person-to-Person Interview

An invitation to participate in an individual interview will be sent to you via email and you will be asked to sign a consent form for participation. You will participate in an in-person or telephone/Skype-based interview with the researcher. In person interviews will occur at a mutually determined location. Each interview will take approximately 2 hours to complete and will be audio recorded so that your answers are taken word-for-word. Broad and narrow interview questions will be utilized and the interviewer will probe as necessary to better understand the descriptions you provide. It is important to note there is no right or wrong answers. It is your experience and perceptions that I want you to describe. Once completed, interview transcripts will be kept strictly confidential.

Participants will be offered a $10 gift card as a token of appreciation for their time and information.

It is expected that approximately 20 participants in total will be enrolled in the entire study. The individual interview and focus group will occur on separate days.

Phase 2: Focus Group

You may be asked to participate in a focus group at Delta Hospital. The focus group is expected to last no more than two hours. A group discussion will be facilitated reviewing preliminary findings from the data collected from the study and further discussion as a group regarding moral distress in the nurse leader role. All focus group sessions will be audio recorded to accurately record your views and opinions, which will later be destroyed according to usual ethically approved methods. Written notes will be taken by an assistant during the focus group in the event there are problems with the recording.

Participants will be offered refreshments and a $10 gift card as a token of appreciation for their time and information.

IMPORTANT: You will not be penalized in any way for information or answers you provide during the focus group and/or interview.

WHAT ARE MY RESPONSIBILITIES?

As a participant your responsibility includes:

- Confirm attendance to the person-to-person interview
- Review and sign this consent form
- Participate in the person-to-person interview at a level which you feel most comfortable. The interview will last no longer than 2 hours.
- Inform the researcher at any time if you wish to withdraw from the study.
- All subjects are asked to keep confidential the discussions that occur.

WHAT ARE THE POSSIBLE RISKS OF HARM AND SIDE EFFECTS OF PARTICIPATING?

Measures have been taken to minimize risks to participant confidentiality. Records will be linked to participants only through a unique identifier and the information used to link records with identifying information will be kept. Information that contains your identity will remain only with the Principle Investigator. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law. Names will not be used during interview or focus groups sessions and participants will be advised to maintain confidentiality of focus group participants and the information they disclose.

Your identity will be kept strictly confidential. The audio recordings of your interview will be transcribed (typed) word-by-word. Names will not be utilized during the audio-taped interview, but any personal identifiers that may inadvertently get included in the recordings will be removed from the written transcript. Electronic files will be password protected and/or saved on encrypted computers for safe mobile storage. The information from your interview will be added to the information from other study participants interviews.

You will not be identified in any of the reports of the completed study. None of your personal information will be included in any of the reports or publications of the completed study. Please note that a transcriptionist service will be used. Audio files will be sent using standard online file transfer systems. Transcriptionists will be made aware of the confidentiality aspect of this study. If a participant is accidentally identified during the focus group or interview, the identifying information will be eliminated from any written transcript. Study documents, including any audiotapes, will be destroyed according to current ethics standards. These measures are expected to minimize any risk to participant confidentiality.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

There may or may not be direct benefits to you from taking part in this study. By participating in this study you will have an opportunity to share your experiences and perceptions of moral distress through a leadership lens and more importantly inform the profession on how you have navigated ethically troubling situations in the Canadian health system as a leader. My hope is that participating in this study will give you an opportunity to share your reflections on your experiences of moral distress ultimately providing new insights and learning about leading nurses within the current health care system in Canada

The researcher hopes to gain a better understanding of moral distress from a leadership context in an effort to share the strategies of coping currently used by nursing leaders for future strategies to support leaders

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. You may withdraw from this study at any time. If you decide to enter the study and to withdraw at any time in the future, there will be no penalty or loss of benefits to which you are otherwise entitled.

The study investigators may decide to discontinue the study at any time, or withdraw you from the study at any time, if they feel that it is in your best interests.

If you choose to enter the study and then decide to withdraw at a later time, all data collected about you during your enrolment in the study will be retained for analysis.

CAN I BE ASKED TO LEAVE THE STUDY?

If you are not complying with the requirements of the study or for any other reason, the study investigator may withdraw you from the study.

AFTER THE STUDY IS FINISHED

There will be no further questions or contact with you related to the study after it has finished. The study investigators may decide to publish a manuscript or present study findings at scientific conventions. No published or presented data will be able to identify you in any way.

Your research-related information will not identify you in any way because all identifying information has been removed such that the information is now anonymous and there is no possibility of linking your identity to your information

WHAT WILL THE STUDY COST ME?

You will not incur any personal expenses as a result of participation.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. However, research and health or other source records identifying you may be inspected in the presence of the Investigator by representatives of Antioch University or the Fraser Health Research Ethics Board for the purpose of monitoring the research.

No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a participant in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a participant in this study will be kept confidential. Information that contains your identity will remain only with the Principle Investigator. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to insure that your privacy is respected and also give you the right of access to the information about you that has been provided to the investigators and , if need be, an opportunity to correct any errors in this information. Further details about these laws are available on request to your study Primary Investigator.

Your research-related information will not identify you in any way because all identifying information has been removed such that the information is now anonymous and there is no possibility of linking your identity to your information.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any questions or desire further information about this part of the study before or during participation, you can contact Jodi-rae Kortje.

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A SUBJECT DURING THE STUDY?

If you have any concerns or complaints about your rights as a research participant and /or your experiences while participating in this study, contact the Fraser Health Research Ethics Board (REB) Co-Chair by calling [telephone number] or Dr. Philomena Essed, Chair of the Antioch University Ph.D. in Leadership and Change IRB.

Appendix C: Consent Form (Continued)

Canadian Nurse Leaders' Experiences with and Perceptions of Moral Distress: An Interpretive Descriptive Study

Consent Form to Participate In a Person-to-Person Interview and Focus Group

You are asked to participate in a research study conducted by Jodi-rae Kortje which is being conducted in partial fulfillment of a Doctoral Degree in Leadership and Change at Antioch University. This consent form is not a contract and as such, you do not give up any legal rights by signing it.

- I have read and understood the subject information and consent form and am consenting to participate in the "Canadian Nurse Leaders' Experience with and Perceptions of Moral Distress" research study.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the results will only be used for scientific objectives.
- I understand that all of the information collected during the person-to-person interview will be **audio-recorded** and will be kept confidential and that the results will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me (if applicable).
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

______________________	______________________	________
Printed Name of Participant	Signature of Participant	Date
______________________	______________________	________
Printed Name of Principal Investigator	Signature of Principal Investigator	Date

Appendix D: Participant Demographic Survey

Please fill out the following questions. This information will not be linked to individual participant's responses and will be used only for the purposes of describing the sample as a group. Providing this information is voluntary.

Participant Identification Number (Assigned for Anonymity by Researcher): Participant ______

Age 20-30 31-40 41-50 51-60 61-70+

Gender Female Male

Please indicate how many years of experience you have as a registered nurse**:**

Please indicate your highest level of education and identify Academic Institution

Diploma: ____

BSN: ____

Post-graduate Specialty Training: ____________________________

Masters: ____

Doctorate: ____

Other: ____

Please indicate how many years you have been a nurse leader:

What formal leadership roles have you filled and length of service?

Charge Nurse _____________________
Patient Care Coordinator_____________
Nurse Educator ____________________
Clinical Nurse Specialist _____________
Advanced Practice Nurse _____________
Director ___________________________
Executive Director ___________________
Vice President ______________________
Other _____________________________

What is your current leadership role:

How many years have you been in this role?

How many hours do you work a week?

What program do you lead within acute care: ____

Is the hospital setting urban or rural? __________________________________

How many employees do you oversee? ____

Appendix E: Sample Guiding Questions for Initial Interview

Researcher

A. Thank the participants for participating in the study

1. Introduction and interest in the research
2. Informed consent process
3. Gather Demographic Survey Information

B. Objective of the study

1. Why the research is being conducted
2. Explain the goals of the research

C. Explanations

1. Length of time of interviews
2. Confidentiality of participants: The discussions that occur while interviewing are confidential. Participant names and any other identifying information will be removed from the data during the transcription process.
3. Participants can terminate the interview at any time
4. There is no right or wrong narrative, participants are free to speak about their experiences
5. Interviews will be audio-taped through audio recording device and supplementary field notes and flip charts may be used to capture information.
6. Any questions or comments

D. Definition of Moral Distress [Read to participant and provide handout of definition].

Moral distress can be defined as the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet due to constraints (real or perceived- i.e. lack of time, supervisory disinterest, medical power, institution policy, or legal limits)cannot carry out this action, thus committing a moral offence. The suffering can present as feelings of anger, frustration, guilt and/or powerlessness associated with a decreased sense of wellbeing. (Mitton et al., 2010, Varcoe, Pauly, Storch, Newton, & Makaroff, 2012).

E. Interview Questions

The following questions have been adapted from previous research (Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Hanna, 2005; Mitton et al., 2010), will be utilized during my interview process to engage deeper understanding and clarity of moral distress within nurse leaders. After two or three interviews, as patterns and themes emerge new questions may evolve.

Interview Questions

Broad Questions:

1. Can you tell me what interested you in my research study?

2. Tell me what it is like working as a nursing leader within the Canadian health care system?

3. What situations or responsibilities do you believe trigger moral distress in nurse leaders? Are there triggers that worsen moral distress for nurse leaders in the Canadian health care system?

Narrow Experience Questions:

1. As defined, would you say that you have experienced moral distress in your current or previous roles in this organization?

2. If so, can you describe the situation(s) or actual moral dilemma(s), i.e. the details/specifics to set the context?

3. Could you describe what this experience (or these experiences) has been like for you, providing specific examples or illustrations? Describe how this experience affected you [i.e. at the exact time you became involved describe the exact feelings you experienced i.e. increased heart rate, self-doubt, etc.]

    a. What action, if any, did you take in the situation you described?

    b. How did you navigate through the situation?

    c. How did your own individual responsibility relate to the degree of moral distress you experienced

    d. Consider how it made you feel, and how it impacted you. Do you recall any immediate physical or emotional responses or effects? To what degree/extent/intensity did you experience these responses or effects?

    e. Were there any short term or long term trade-offs were, i.e. consequences like time off work, personal ill health, frustration with self, colleagues, your position, the organization, etc.

    f. What did you do at that time to alleviate these effects?

    g. Did you realize you were experiencing moral distress immediately or was it a delayed recognition?

    h. Were there any supports for you as a leader to help you navigate this situation? If

so what were they? [Are your supervisors understanding of the impact of moral distress in your situation?] Could you turn to someone or access organizational resources?

i. Who was it and what were their recommendations to you to overcome or deal with the situation or your reaction?

j. Did you feel vulnerable or safe disclosing that you were experiencing moral distress?

k. Describe any support, resources or actions of others that could have helped or hindered this situation.

4. What did this experience mean to you as a nurse? What did it mean to you as a leader?

5. How did it impact relationships between your peers and followers? Did this create any further conflict or distress?

6. How frequently do you believe you encounter moral distress?

7. What effect, if any, do you think this has had on your personal life? What did this mean to you as a woman (man)? As a wife (husband), parent? How were you able to balance or detach from the impact of this event so that it didn't impact your life at home?

Narrow Perception Questions:

1. What did you perceive as the morally difficult elements of this situation for you and how did it make you feel?

2. What factors assisted or prevented you in resolving the problem?

3. What was the worst part of this ethically experience? The second?

4. What did you learn from the experience? Was there a positive aspect of this experience?

5. What character traits lend well to managing moral distress and navigating through these ethically difficult situations?

6. Reflecting on the situation and your position in the organization, do you feel that those in leadership roles above you experienced moral distress in this situation? What about policy leaders and governments? Please explain.

7. What effect, if any, do you think moral distress had on patient care and the organization in this situation and other situations caused by moral distress?

8. What effect if any, do you think moral distress had on those employees you lead? Did this create a further conflict?

9. What variables at an individual, organizational, and/or political level do you think are related to and/or contribute to moral distress?

10. Do you distinguish moral distress as something different from or related to burnout, vicarious trauma, secondary trauma, emotional distress? If so, explain.

11. How would you describe the structures, policies, and practices of the hospital organization in fostering respect and support for leaders as they navigate through the complexities of ethical clinical issues?

12. What else should be asked about this topic for future interviews in order to get information that will be useful for helping the organization and policy makers support leaders in situations that can create moral distress?

Narrow Navigation Questions:

1. Have you ever felt as if your role as a leader constrains you from carrying out your professional values? Please describe. How did you navigate this?

2. In your role as a leader, has your voice about situations triggering moral distress been suppressed? If so by what and why?

3. What organizational resources are in place to assist leaders in dealing with moral distress? Are they effective, applicable, and useful?

4. What approaches/resources do you utilize and recommend to mitigate the impact of moral distress for you personally?

5. In lieu of the complexity of the health care system today and the accompanying pressures, what keeps you in your role and what do you recommend as an approach to maintain a positive quality of life?
    a. Have you ever thought about resigning from your job due to moral distress or the frequency of moral distress within the work environment?

6. Is there anything else about the moral distress you experienced in relation to work that you want to share about your experience?

F. Conclusion

Thank participants, provide contact information and honorarium.

Appendix F: Sample Guiding Questions for Focus Group

Researcher

A. Thank the participants for participating in the study

1 Introduction and interest in the research
2 Introduction of Research Recorder
3 Informed consent process
4 Gather Demographic Survey Information

B. Objective of the study

4. Why the research is being conducted
5. Explain the goals of the research

C. Explanations

6. Length of time of interviews
7. Confidentiality of participants: The discussions that occur while interviewing are confidential. Participant names and any other identifying information will be removed from the data during the transcription process.
8. Participants can terminate the interview at any time
9. There is no right or wrong narrative, participants are free to speak about their experiences
10. Interviews will be audio-taped through audio recording device and supplementary field notes and flip charts may be used to capture information.
11. Any questions or comments

D. Definition of Moral Distress

Moral distress can be defined as the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet due to constraints (real or perceived- i.e. lack of time, supervisory disinterest, medical power, institution policy, or legal limits)cannot carry out this action, thus committing a moral offence. The suffering can present as feelings of anger, frustration, guilt and/or powerlessness associated with a decreased sense of wellbeing. (Mitton et al., 2010, Varcoe, Pauly, Storch, Newton, & Makaroff, 2012).

E. Review of Emerging Themes and Reflections to Date

Facilitate reflective discussion on the data to date. Analysis of the data concurrently with data collection is used in the focus group using a constant comparative approach which enables the researcher to develop further questions and further exploration during the group interaction. The following questions will be used as a guide if necessary for further clarity on emerging themes.

F. Interview Questions

The interview guide will be built from evolving patterns and themes from data analysis. The following examples are preliminary sample interview questions. No confidential individual information will be disclosed in the focus group.

Sample Interview Questions:

1. What was the experience like for you to spend a couple of hours reflecting on your experience of moral distress?
2. Tell me about your reflections after our interview?
3. Are there any other experiences of moral distress that should be discussed?
4. After reviewing the preliminary findings are there any 'take home' messages that should be highlighted about the experiences, perceptions and navigation of moral distress within nurse leaders?
5. Are there any patterns, commonalities or diversities that you notice that are absent?
6. Are there any of the other elements that contribute to moral distress within leaders or recommendations that are missing?
7. Do you feel that your experience and voice about moral distress has been accurately captured in these findings?

G. Conclusion

Thank participants, provide contact information and honorarium.

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