

Moral Distress: Its Impact on Nursing

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Disclaimer/Disclosures

Requirements for successful completion: read the entire study, complete the post-test with a score of 80% or higher, complete and submit the evaluation form, and complete registration information, including full name and credentials.

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Purpose: This study is designed to provide the learner with information to aid in identification of and intervention for moral distress in the practice environment. The purpose of this study is educational in nature. It is not intended to provide clinical or legal advice or to be a comprehensive compendium on evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal resource, or facility policy.

Objectives

1. Define moral distress.
2. Describe ways nurses can proactively address moral distress in the healthcare environment.

Introduction

This study addresses the concept of moral distress – what it is, why it exists and how it affects nurses as members of the healthcare team. Based on an understanding of the

issues involved, nurses can take steps to be proactive instead of reactive – to develop strategies to address moral distress so it does not become a barrier to safe, effective patient care.

The Concept

Have you ever felt like you knew the best thing to be done for a patient but felt that you couldn't do it? Have you sometimes wanted to “break the rules” because there were policies and procedures that prevented you from doing what you thought was best in a situation? Have you ever felt frustration because you sensed that the patient's voice wasn't being heard when decisions were being made about care? If you have felt any of these things, you have experienced moral distress.

Moral distress is defined as “psychological disequilibrium” that occurs when, for whatever reason, the nurse is not able to provide the care that is perceived to be “right” or “best” for the patient (Corley, 2002). This may include situations of omission (care perceived to be appropriate is not able to be provided) or situations of commission (the nurse provides the care, even though he/she does not perceive it to be “right” for the patient). Each of us has “morals” that frame our thinking and actions. These morals are developed from our upbringing, culture, spiritual frame of reference, education, and many other factors. The term “ethics” is used to refer to the study of moral behaviors and decision making. In the healthcare world, we often refer to “clinical ethics” as those moral dilemmas resulting from clinical situations. Organization ethics relates to the “right” way people are expected to behave as employees within the organizational structure. Moral distress for the nurse can result in either the organizational or clinical context.

The American Nurses Association (2002) suggests a slightly different definition:

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 judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing.

With either framework, it is clear that there are “disconnects” between what is perceived to be “right” and what is actually done. It is these disconnections that provide moral distress for the nurse.

Fundamental to the practice of nursing is the expectation that the nurse will always keep the patient from harm, will provide care that is safe and effective, and will be respectful of the dignity, worth, and autonomy of the patient. The Code of Ethics for Nurses (ANA, 2001) supports these premises. However, this very foundation inherently creates situations where moral distress will occur, because there will always be situations where the nurse cannot do what is considered to be in the best interest of the patient. Therefore, it is inevitable for moral distress to occur. The keys are to (1) recognize situations where

moral distress is occurring or might occur, and (2) develop strategies that the nurse can use to minimize its effects.

Code of Ethics

One of the characteristics of a profession is that it has its own culture, with expected behavior of those who are members. Nursing has a code of ethics that provides the cultural framework within which nurses practice. The most recent version of the code of ethics was published by the American Nurses Association in 2001. There are nine basic precepts included in the code. The three of these which are most likely to resonate with the theme of moral distress will be included in this study.

The first statement in the Code of Ethics is that the nurse “practices with compassion and respect for the inherent dignity, worth, and uniqueness of each individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (ANA, 2001, p. 4).

On the surface, it would appear that this statement is consistent with peoples’ value systems and those of health care facilities and other providers. In reality, though, there may be situations that arise in practice that cause distress to the nurse because he/she feels that care is unable to be provided with these considerations in mind. Consider, for example, the case of the medical practice that makes the decision to not accept Medicaid patients because the reimbursement rate does not cover the costs of the care provided. The nurse working in that practice may feel conflicted, because the moral position is that care should be provided to each person who needs it, regardless of condition or ability to pay. The reality of the situation, however, is that persons who are receiving Medicaid assistance are not able to be seen and provided care in that practice setting. Conflict in values occurs from two perspectives: the nurse is aware that the patient’s needs are not being met, and the nurse is unable to change the system within which these decisions are made.

The second statement in the Code of Ethics is that the nurse’s “primary commitment is to the patient” (ANA, 2001, p. 4). Again, on the surface, most nurses would state that they believe in this concept and implement it in their practice. Yet there are many times when the nurse feels frustration at not being able to spend the desired amount of time with the patient due to system constraints such as low staffing, non-direct patient care duties, and restriction of overtime hours. Some have argued that the primary commitment of the nurse is, in reality, to the employer, with the patient’s needs being secondary to following the policies, procedures, and processes of the employment setting.

The third statement in the Code of Ethics is that the nurse “promotes, advocates for, and strives to protect the health, safety, and rights of the patient” (ANA, 2001, p.4). Distress is often evident in regard to this ethical tenet when there are differing perceptions of what is “right” for the patient. Patient rights have become a major issue in healthcare facilities, sometimes to the point that providers and patients alike forget that there are two components to the process – the correct focus is really on *both* patient rights and patient

responsibilities. Does the patient have the “right” to determine what medication he should be taking or to demand a specific diagnostic test or treatment? Does the patient have the “right” to engage in behaviors that complicate the plan of care – like smoking with home oxygen in place?

Nurses must use caution in reflecting on this standard in the code of ethics. What does it really mean to advocate for patients’ rights? What rights? Under what circumstances? When might a patient’s engagement of rights impinge on the rights of staff, or of another patient? Whose needs take priority when that happens?

Just how does the nurse go about advocating for the patient? Advocacy can take many forms. Implementing “best practices” to promote patient safety on a patient care unit is one way nurses can advocate for their patients. Serving on a quality improvement committee to look at revising a process for implementing a particular procedure is a way the nurse can speak up on behalf of what works best for the patient. Asking a colleague for help when a patient’s needs are very complex and time-consuming is an example of patient advocacy. In this case, the nurse may feel that he/she “should” be able to handle the care needs alone, but the astute nurse will recognize the need for assistance and seek appropriate support. In all of the above situations, the nurse has recognized an area of concern, taken positive steps to address that concern, and been an active part of the solution toward solving the problem. These are all proactive steps to minimize a sense of moral distress.

What happens when the nurse feels that the plan of care suggested by the physician is not in the best interest of the patient? A nurse feeling moral distress may be inclined to carry out the plan without question, all the while feeling frustrated and sometimes angry that the plan is not optimal for the patient. A nurse who feels empowered, on the other hand, will talk frankly and respectfully with the physician to share perspectives and explore what each feels is “best” for the patient.

In many cases, nurses are supported in their efforts toward patient advocacy by laws and/or rules from their regulatory boards. For example, rules promulgated from the law regarding the practice of nursing in the state of Ohio require that nurses consult the prescriber for clarification when in doubt about a prescription that has been ordered for a patient (4723-4-03[E][2]OAC for RNs, 4723-4-04[E][2] OAC for LPNs). These rules support the nurse in (1) critically analyzing the patient and the patient’s needs in relation to the prescription, (2) consulting the prescriber to discuss any questions about the prescription, and (3) collaborating to develop a plan that is in the best interest of the patient under the current circumstances. It is important to realize that the nurse, the physician, and the patient may not always agree on what is “best”, but having these frank discussions where different viewpoints are shared and considered empowers the nurse to be an effective member of the healthcare team and helps to mitigate feelings of moral distress.

Nurses suffer moral distress when there is incongruence between the care that is *able* to be provided and that which the nurse perceives *ought* to be provided. Factors that can

influence this imbalance can include such things as policies and procedures that a nurse feels to be restrictive, lack of prescriber orders for what the nurse perceives to be the most effective medication for a patient, lack of time to implement the desired care, lack of human or material resources to provide the care thought to be appropriate, and differences in opinion among members of the healthcare team about what care is appropriate for the patient. There may also be situations where family members are not in agreement about a proposed plan of care, leading to a delay in offering care that is deemed to be in the patient's best interests.

Causes of Moral Distress

Hamric (2010) identifies two key issues that are typically present in situations involving moral distress: a power gradient, and issues within the healthcare system that complicate individual patient situations. There has historically been an imbalance of power in the relationship between a nurse and physician in the healthcare setting. Physicians have been perceived as those who "give the orders" and nurses as the ones who "follow the orders". When the nurse feels that his/her obligation is to "follow the orders", there is a sense that he/she has no control over the decisions that are made affecting the patient. When the nurse has had extended opportunity to get to know the patient and is perhaps aware of situations that the physician doesn't know about that influence the patient's decisions, the frustration grows when the nurse believes the physician is pursuing a plan of care that is not perceived to be in the best interest of the patient.

The differing perspectives of nurses and physicians can lead to feelings of moral distress (Hamric, 2010). The physician's focus is often on the "survival of the few", while nurses focus on the "suffering of the many". While these value systems are both admirable, they do lead to tension between the nurse and the physician as members of the healthcare team. This tension has been supported by research studies of staff nurses. In one study (Elpern, Covert, and Kleinpell, 2005), the majority of critical care nurses surveyed identified a "moderate" level of moral distress in their daily work. They cited feeling like they were "keeping dead people alive" or feared causing undue suffering by following a plan of care that was perceived to be too aggressive.

An important issue to keep in focus here is that we live in a complex world and work in complex healthcare systems. Rapid advances in technology have led to medical and surgical interventions that once were considered beyond the realm of possibility. Further, pressure from families and loved ones, often based on unrealistic expectations garnered from the media or other sources, often leads to the request for healthcare providers to "do everything you can", even when it seems that further intervention would not change the course of the patient's disease process or post-accident status. There are no easy or quick "answers" to many of the challenges that nurses face in working with people of all cultures, belief systems, and backgrounds. In fact, most of the time, healthcare providers are working in "shades of gray" with no text-book perfect solutions to every challenge.

This is particularly apparent in cases where there are difficult choices to be made in regard to care options. Moral issues and decisions are inherently different than clinical

issues and decisions. In the clinical context, if a patient has an infection, an appropriate antibiotic can be prescribed to treat that infection. If a patient has hypertension, an antihypertensive medication can be prescribed to treat that high blood pressure.

However, if a patient chooses a different option than to follow the prescriber's recommendation, now a different scenario presents itself for nursing intervention. Here are some of the factors to be considered in this situation:

- Is the patient choosing not to follow the recommendation because of a lack of knowledge about the proposed treatment and its effects? If so, this is an issue that can be addressed through patient education.
- Is this a choice based on the fact that the patient does not have the resources (such as money, supplies, or equipment) to carry out the plan? If so, this is an issue that can be addressed through identification of resources needed and exploration of ways to attain those resources, if possible.
- Is the issue that the patient understands the treatment plan, has the resources to implement the plan, but doesn't see the value in the plan? If so, the nurse can explore with the patient the risks and benefits of the plan, explain the expected outcomes, and assist the patient in thinking through the choices. Further consultation with the physician may also be helpful for the patient.
- Is the issue that the patient has the knowledge and resources and sees the value of the plan, but doesn't believe that it is the "right" option for him? Now we have a different puzzle that isn't so easy to solve.

What frame of reference supports the patient's notion that this is not the "right" option? There often are religious/spiritual, cultural, familial, or other values that guide the patient in his/her decision-making. These deep-seated values guide the patient's thinking, not only in regard to this issue, but in *life*. We call these values a person's "morals". It is not within the purview of the healthcare team to change these values or "make" the patient believe differently. What is critical is that the nurse acknowledge and accept the frame of reference that guides the patient's decision-making. Once this is done, the nurse can then explore other options that may assist the patient to consider acceptable ways to address the current problem. This, in turn, empowers the nurse to work collaboratively, rather than at cross-purposes, with the patient and other members of the healthcare team. This action eases the moral distress.

Unfortunately, patients who choose, for whatever reason, not to follow a designed plan of care are often termed "noncompliant". The nurse then feels frustrated, and sometimes angry, that the patient "doesn't do what he's told". This is a classic case of the healthcare team "assuming" it knows what's best for the patient without validating that belief with the patient himself. Due to lack of time, lack of interest, lack of support, or a myriad of other factors, the nurse may not have the opportunity to dialogue with the patient about

his decision not to follow the plan of care, as depicted in the previous paragraph. When this sharing does not occur, there is distress on the part of the nurse that is not relieved.

Moral distress also arises from other types of challenges that nurses face in the healthcare system. There may be dilemmas stemming from laws that prohibit taking the action the nurse thinks is best (the nurse believes that cannabis may be the drug of choice to relieve the patient's terminal pain, but laws in the state where the nurse practices prohibit prescribing and/or dispensing of medical marijuana). There may be dilemmas stemming from perceptions of lack of compliance with such things as healthcare financing regulations or accreditation criteria. While these may not directly impact care of a particular patient, they cause distress for the nurse because they are perceived to interfere with the way the nurse believes the job should best be done.

A critical initial step for the nurse is to assess his/her own feelings of distress. What is causing the discomfort? What contributes to the feeling the nurse has that he/she is powerless to make a situation different than it is? Once the specific cause of the frustration has been identified, strategies can then be developed to address the specific area of need. Often, distress is general in nature, resulting in overwhelming feeling of being out of control and not being able to make things better. Clear recognition of the issue at hand, however, serves to focus the target of the distress. Once the target has been identified, the nurse then has the opportunity to consider specific ways to hone in on the specific area of concern. This is empowering, giving the nurse a focus for his/her energy and can lead to productive problem solving. Often the result is system change that affects not only the current situation but changes the way the system functions so similar dilemmas can be avoided or at least addressed more appropriately and in a more timely fashion in the future.

The following table, while not all-inclusive, lists examples of types of situations that can cause feelings of moral distress in the nurse:

Table 1: Examples of Situations Causing Moral Distress

➤ System issues - Examples
○ Laws – General
○ Laws and rules – nursing practice
○ Compliance / Adherence
• Financial regulations
• Accreditation criteria
○ Policies and Procedures
○ Culture of the system
• Punitive in nature
• Unsupportive of nurses and nursing
○ Complexity of the system
○ Use of technology
○ Staffing

➤ Interprofessional Issues – Disrespect, lack of collaboration
○ Nurse / Nurse
○ Nurse / Physician
○ Nurse / Other member(s) of healthcare team
○ Different cultural perspectives/values
➤ Patient / Family Issues – Choice to not follow a plan of care
○ Education / Knowledge
○ Lack of available resources
○ Lack of perceived value of plan
○ Different moral perspective

The Impact

Moral distress has been found to contribute to nurses' unhappiness in their jobs, and sometimes with the profession altogether (Elpern, Covert, and Kleinpell, 2005). Evidence of this unhappiness can be seen in physical stress-related symptoms, such as headaches, insomnia, hypertension, and gastrointestinal upset. Mentally, the nurse may feel "bogged down", overloaded, anxious, and frazzled. The focus becomes doing the technical aspects of the job without the caring and critical thinking that is so critical to safe, high-quality nursing practice. Both mental and physical manifestations of stress can impact job performance, leading to errors in patient care. The nurse may have frequent absences from work, may choose to change jobs, or may leave nursing altogether. Ultimately, the patient suffers, and the profession of nursing suffers.

Need for a New Approach

Corley (2002) suggests that the typical approach used by nursing education programs is not effective in preparing new nurses to deal with moral distress that is encountered in practice. Curricula typically include theoretical information about ethics and may speak to the concepts of autonomy, nonmaleficence, beneficence, and justice. However, until the nurse has an experiential base from which to understand and apply these concepts, there is not clear understanding of how tangled these approaches actually are.

For example, a true focus on autonomy would presume that the patient has the "right" to make his own decisions about the plan of care. He may be considering whether he wants to stop his dialysis care, with full awareness of the implications of this decision. The person who has capacity to make that decision has the right to do so, but the nurse may feel a great deal of distress because he/she doesn't think that is the "right" thing to do. The frame of reference the nurse is coming from values life and works to maintain the best quality of life possible, given the chronic disease condition the patient has. The patient, on the other hand, is coming from the perspective of fatigue, awareness that quality of life will not improve, and other factors suggesting that further medical intervention is futile. The nurse feels moral distress in knowing that his/her desire to provide on-going dialysis care for this patient is no longer possible. A novice nurse tends

to feel very overwhelmed and anxious in this situation. A more experienced nurse may look at the same situation, understand the patient's frame of reference, and be able to shift the focus of his/her care from treatment to palliative support. While this nurse still feels moral distress, the nurse has learned to accept that situation, acknowledge that the decision is out of his/her control, and then "switch gears" mentally to be able to work with the patient with a new goal in mind.

Historically, nurses have been rather passive in terms of making change in the way things work on a nursing unit or in a healthcare facility. Nurses may bemoan the situations in which they find themselves, but often do not assertively work to make things different. It is a source of considerable frustration to nursing leaders when staff complain about a situation but then are unwilling to serve on a process improvement team or participate in some other type of initiative to make the situation better.

Nurses sometimes feel powerless to make change in the way a hospital unit works or in the way care is provided. Unfortunately, past history has shown that the voice of the nurse is often not valued in acknowledging areas of needed improvement. When one has attempted to make concerns known and these attempts are either ignored or blatantly dismissed, the nurse soon loses the momentum to try to make change. The resultant behavior, then is to "put in the time", do one's job, and leave. The professional investment in quality care becomes lost.

The world of healthcare is very complex. In academic education, as well as in continuing education, there needs to be a focus on the complexities in which healthcare is being provided as a framework for understanding the moral distress that occurs within the system. Simply teaching a student or new staff nurse how to perform skills does not prepare that person to work within the complexity of a highly technological, high-stakes environment. Benner, et al (2010) suggest that "ongoing dialogue between information and practice" is critical to enabling and empowering nurses to be agents of change.

The American Association of Critical Care Nurses has published a position statement (AACN, 2008) on the topic of moral distress, calling it a serious problem in nursing that results in significant physical and emotional stress. This organization advocates that every nurse and every employer are responsible for working toward strategies to mitigate the potentially harmful effects of moral distress on both patients and nurses. The position statement outlines steps that can be taken by the individual nurse and by the employer in order to empower nurses to be actively engaged in addressing the issue. Note that the position statement clearly does not say that moral distress should be eliminated; rather the imperative is to recognize and proactively deal with this issue.

Writing in the January, 2010, issue of the Online Journal in Nursing, Dr. Marla Weston discusses the concept of control over nursing practice. She advocates that autonomy in nursing includes "the ability to act according to one's own knowledge and judgment", within the framework of relevant laws, rules, and organizational policies and procedures. Given that moral distress is a factor in the context in which nurses practice, part of the value of control over one's practice is the ability to participate actively in strategies that

will empower nurses to affect change. This may occur in the form of new policies and procedures, new process improvement initiatives, or new strategies through which nurses and physicians collaborate. Weston cites numerous sources supporting the fact that autonomy and control over nursing practice have a direct impact on the quality of nursing care provided to patients.

In October of 2010, the Online Journal in Nursing (OJIN) will be publishing comments related to the topic of “Moral Courage Amid Moral Distress: Strategies for Action.”

Further information can be accessed at:

<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Announcements/Upcoming-OJIN-Topics.aspx>

Hamric (2010) suggests three levels of intervention that can help to ameliorate moral distress. The first is the patient level. Open, honest, and respectful dialogue among members of the healthcare team can help to address patient-related areas of distress. While clearly every member of the team will not always have his/her preferences followed, at a minimum, each voice will be heard, and each person’s viewpoint will be respected. Second-level intervention occurs at the unit level, where team members can learn from past successes and not-so-positive situations and can strategize together about how to avoid or minimize problems in the future. Finally, an organization-wide initiative can be undertaken to look at policies, processes, and the culture within which care is provided. Changes can be instituted to recognize and proactively address moral distress.

Ethics Committees

Facility ethics committees can be a source of support and referral for the nurse. Moral dilemmas do not need to be addressed alone. Often, being able to share concerns with others, work through thoughts and feelings about a particular issue, and have an objective group provide different ways of looking at a problem is extremely helpful.

It is important to realize that ethics committees are not “fire departments”. They are not the resource to call when quick, emergency decisions are needed. Ethics committees, by their very definition, are advisory in nature, existing to assist the direct care providers in working through dilemmas that are impacting or have the potential to impact patient care.

Typically, ethics committees are interprofessional. Members on ethics committees usually include representation from medicine, nursing, social work, and pastoral care. Depending on the setting, other disciplines, such as physical therapy or respiratory care, may be involved.

A nurse may feel reluctant to make a referral to an ethics committee for several reasons. Sometimes the nurse feels that “I should be able to handle this problem by myself” or “Other people don’t think this is as important as I do”. There may be fear that the concern won’t be heard or validated. One possible approach is to schedule a one-on-one meeting with a member of the ethics committee. Use this opportunity to explore the purpose and functions of the committee, share the current concern, and get some feedback from this

person about whether the dilemma is truly appropriate for ethics committee involvement. Sometimes, this person may direct the nurse to another resource that is more appropriate (this may be the legal department or social services, for example). At other times, this person may well feel that the issue is appropriate for full committee deliberation. The nurse thus has the opportunity to validate his/her concerns in a confidential venue and get support from the member of the committee to move the issue forward.

Typically, staff are asked to participate in ethics committee consultations. There may be one or two staff present, or there may be a full interprofessional team, depending on the situation. Members of the ethics committee are able to objectively listen to the various points of view, help people problem solve and explore options, and assist in the development of a plan of action. The role of the ethics committee is not to implement the action plan, but to facilitate the team's work in moving the plan forward.

This process, too, empowers the nurse to realize that he/she is not alone – that there are resources available to provide guidance and direction. Being able to utilize resources appropriately and see positive results of that referral are empowering for the nurse and serve to alleviate the moral distress.

Empowering Nurses

Fundamental to the process of easing moral distress is empowering nurses. This can occur in several ways. Consistent with Hamric's (2010) suggestion of "levels" of action, nurses at the bedside can be encouraged to be more vocal in presenting their perspectives regarding patient needs, based on nursing assessments. This best occurs in an environment that is supportive of nurses and nursing, creates a culture in which interprofessional dialogue is encouraged, and provides opportunities for nurses to round with physicians and otherwise engage in dialogue.

At the unit level, nurses can be supported by managers, clinical nurse leaders, or others to participate in review of evidence-based practice literature, become members of quality improvement teams, and engage in other systematic processes for addressing policies/procedures or guidelines that have been identified as contributing to moral distress. Similarly, managers must recognize that moral distress is inevitably going to occur in the practice of nursing. Encouraging nurses to take care of themselves by taking time for breaks and nourishment, maintaining hydration, and using "relaxation" breaks to ease the tension of the work environment will yield several benefits: nurses will feel better physically, will be more mentally alert, will feel supported and encouraged, and will be more alert to the needs of their patients. In this environment, nurses will feel empowered. Continuing education activities can be developed and presented to aid nurses in identifying situations where moral distress occurs and developing of strategies to minimize its impact. A supportive work environment will enable the nurse to transition this learning from concept to reality.

At the organizational level, nurses need to be not only encouraged but expected to be at the table for discussions about system-wide initiatives and process changes. Nurses are

sometimes asked for their input, but decisions are made without their direct participation or sometimes without regard to the input they have provided. Having nurses on senior leadership teams is helpful, but nurses at the bedside are the true voice of the needs of the patient within the system. Their voices must be heard and respected.

Only relatively recently has the focus in both healthcare education and practice begun to shift to a true interprofessional model, recognizing the strengths and contributions of each discipline in providing quality patient care. Newer nurses will likely receive some education in this process, but more tenured nurses can benefit from continuing education, case studies, interprofessional dialogue, and simulation experiences as opportunities to learn more about what their colleagues bring to the patient situation and how the interprofessional team can best work together.

Much of the healthcare environment continues to operate on a more hierarchical, traditional model, with the nurse seen in a less powerful position than the physician. As transitions in healthcare occur, this model is changing. One factor which has influenced a change in perceptions and roles has been the advent of the physician hospitalist, who is typically an employee of the hospital rather than an attending physician who has “privileges” at the hospital and makes rounds once or twice a day. Having both nurse and physician as employees of the system changes the balance of power and often provides for a more collaborative working relationship.

The individual nurse is accountable for his/her own practice. Much can be said about changing organizational culture, changing policies/procedures, and making other systemic changes. However, ultimately, the accountability for a nurse’s practice rests with that nurse. The nurse choose to perceive that he/she has no power to change a situation and act the role of “victim”, or the nurse can assume a more proactive role in critically analyzing a situation and looking to see what he/she can do to address the moral distress that is being felt. For example, review the table on page 7 when dealing with an issue that is causing distress. Rather than simply feeling frustrated, use critical analysis to determine what type of situation is involved, who the people are in the situation, and what about the situation is causing the distress. Then think about whether there is anything you can do to address the problem. If so, take the initiative to do something about it. If not, take a deep breath, recognize that the issue is beyond your control, and stop feeling frustrated by it.

Individually, each nurse has the ability to address the issue of moral distress and work to minimize its effects. Together, as members of the healthcare team, we have the ability and the opportunity to work together to address issues of mutual concern. This collaborative relationship-building will enhance the function of members of the team, and, best of all, will enhance the quality of patient care.

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