

**MORAL DISTRESS IN EMERGENCY DEPARTMENTS:
EXPERIENCES OF REGISTERED NURSES**

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Bachelor of Nursing, University of Lethbridge, 2007

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfilment of the
Requirements for the Degree

MASTER OF SCIENCE IN NURSING

Faculty of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

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Abstract

The purpose of the study is to determine whether registered nurses are experiencing moral distress while working in emergency departments, and if so, the causes and their reactions to the phenomenon. Registered nurses currently employed in an in emergency department engaged in semi-structured interviews to examine the phenomenon. This study utilized narrative inquiry research design as advocated by Reissman (2008). Findings indicated that registered nurses are experiencing moral distress in emergency departments related to myriad pressures and demands forcing simultaneous decisions primarily related to use of the finite number of resources at their disposal and the provision of futile care. Participants' reactions to moral distress included acknowledging that they will continue to find themselves in morally distressing situations, passion for their jobs despite encountering morally stressing situations, and an ability to manage negative effects of moral distress related to their personalities and the nature of the working relationships that exist within emergency departments. Findings indicate that health care administrators, staff, and physicians require increased awareness of the phenomenon if they wish to address and mitigate these situations.

Acknowledgements

I wish to express my sincerest gratitude to the participants in the study. Your insight and engagement is both appreciated and motivating. The passion to you expressed for your work and your workplaces is also inspiring. It is my hope that your constant desire to improve your environments translates into improved patient and staff experiences.

I am profoundly grateful to my supervisor, Dr. Brad Hagen, whose wisdom and guidance has been invaluable. I am further thankful for your patience and willingness to share your experience throughout this process.

To the members of my Thesis Committee, Dr.'s Monique Sedgwick and Linda Fehr, thank-you. To Dr. Sedgwick, thank-you for providing insight on the frontline clinicians' perspective and for your dedication to research endeavors. To Dr. Fehr, thank-you for your positive approach to research and for providing perspectives not previously considered.

A special thank-you to my family for your unwavering support, understanding, and for your patience with me throughout this work. You are the reason that I have persevered.

Table of Contents

Abstract	iii
Acknowledgements.....	iv
Table of Contents.....	v
Chapter 1.	
Introduction.....	1
Chapter 2.	
Comprehensive Moral Distress Literature Review.....	10
Chapter 3.	
Reasons Emergency Department Registered Nurses Experience Moral Distress.....	29
Chapter 4.	
Registered Nurses Responses and Reactions to Moral Distress While Working in the Emergency Department.....	62
Chapter 5.	
Discussion.....	84
References.....	93
Appendix A –Recruitment Poster.....	102
Appendix B –Letter of Invitation to Registered Nurses.....	103
Appendix C –Letter of Consent.....	104
Appendix D –Interview Guide.....	106
Appendix E –Participant Demographic Information.....	107

Chapter 1

Introduction

This qualitative research study of registered nurses' experiences of moral distress while working in emergency departments was completed in order to contribute to the growing body of literature on the phenomenon of moral distress. Moral distress has been widely studied in critical care areas but seldom examined in emergency department settings. Findings from this study offer insight into causes of moral distress and registered nurses' reactions to moral distress while working in emergency departments. This information can be utilized to address and mitigate circumstances currently contributing to the instances of moral distress in the highest acuity, highest patient volume, area of nursing, the emergency department. The final thesis product will consist of five chapters including an introduction and conclusion. The three chapters in between will consist of articles on the topics of: "Moral Distress in Nursing: A Literature Review"; "Causes of Moral Distress in Emergency Department Registered Nurses"; and "Emergency Department Registered Nurses Reactions to Moral Distress."

Statement of the Problem

Background and Context

The emergency department is a specialty area that serves all ages of patients presenting with a broad spectrum of complaints. Unlike other specialty areas, there are no restrictions or limitations placed on the type of patient that registers and is treated in the emergency department. As a result, those working in emergency departments must be prepared to care for myriad conditions simultaneously and often without warning. Many healthcare professionals have reported that the emergency department is the most stressful environment in hospitals. Karr

(2006) reported emergency room nurses work in an environment that is volatile and challenging due to frequent exposure to critical incidences and stressful events. Furthermore, the number of patients presenting to emergency departments continues to increase while the acuity of many of these patients is also increasing as the number of patients presenting with multiple comorbidities is rising. Many patients who present to the emergency department indicate that they have difficulty accessing primary care and their family physician. Fifteen percent of Canadians report they do not have a family physician (Olah, Gaisano, & Hwang, 2013). According to Knapman and Bonner (2010), it is important to recognize the multifactorial aspects of waiting times and the importance of efficiency in all aspects of care in order to understand the environment and culture of emergency medicine.

Rationale and Purpose

Research literature has repeatedly demonstrated that Intensive Care and Critical Care Units have nurses who display high levels of moral distress (Corley, Elswick, Gorman, & Clor, 2001; Elpern, Covert, & Kleinpell, 2005; Shorideh, Ashktorab, & Yaghmaei, 2012) yet the most closely related specialty area in all of nursing, the emergency department, is virtually absent from the literature on the topic of moral distress. Therefore, the purpose of the study is to determine whether registered nurses are experiencing moral distress while working in emergency departments, and if so, the causes and their reactions to the phenomenon.

Approach to Research

Research design

Narrative inquiry was used to explore registered nurses experiences of moral distress while working in emergency departments. Chase (2005) indicated narrative inquiry is a form of

investigation and data collection that retains a narrative-like quality from social life. Reissman (2008) wrote of researchers utilizing narrative methods because of the truths that stories reveal. She further indicated telling stories about challenging times in our lives includes emotions and creates order, which in turn, enables a search for meaning and promotes connection with others. The goal in narrative interviewing is not to generate brief answers or general statements, but rather to gather detailed accounts (Reissman, 2008). Emergency department nurses share a relatively common context to complete their work. However, their challenges, experiences, truths, and emotions are not necessarily common, making narrative inquiry an appropriate way to study the phenomenon of moral distress. Chapters 3 and 4 include detailed research approach descriptions.

Sample and setting

A non-probability sampling technique was used. I recruited participants for the study by e-mailing potential candidates who work in emergency departments throughout the province. Inclusion criteria included working at least 30 hours per week as a registered nurse in the emergency department for a minimum period of at least 2 years. Those working in the zone where I am employed were excluded related to my current and previous emergency department positions within that zone. I sent a letter of invitation (Appendix B) to those who responded to the e-mail invitation (Appendix A).

According to Glesne and Peshkin (1992), consideration for having a large number of cases in a study includes ideas for subsequent generalizability which is a term they claim means little to most qualitative researchers. Transferability is a more realistic and achievable goal in qualitative studies.

Data Collection

The majority of the interviews were completed by video teleconference using Skype with the remainder occurring face-to-face at a location of the participants choosing ($n = 12$). All of the interviews were between one and two hours in length and began with the confirmation of consent. As advocated by Neuman (2011), open-ended, non-directional questions with additional probing questions were used throughout the interviews as participants relayed their experiences of moral distress while working in emergency departments. All of the interviews were digitally recorded and I subsequently transcribed each of them verbatim.

Data Analysis

I used thematic analysis which is one of the most common approaches used by qualitative researchers, to analyze the data. Thematic analysis can be used with most theoretical frameworks as it is not linked to a particular framework (Braun & Clarke, 2006). Reissmann (2008) indicated thematic analysis is one of the four general approaches used within narrative analysis. Types of analysis are not mutually exclusive and overlap of techniques can be expected in analysis of qualitative data. Ultimately, I connected theoretical ideas to the text, interpreted the text and made interconnections between the codes resulting in the ability to make notes on the relationships between the codes, the research questions, and the moral distress literature.

Qualitative research using narrative forms is increasing and trustworthiness must be sought and maintained throughout the study. Trustworthiness is ensuring that data was ethically and appropriately collected, analyzed and reported (Carlson, 2010). Persuasiveness and rhetorical style may convince the reader of the truth within the content but does not necessarily provide the context and will not stand up to academic questioning (Reissman, 2008). Audiences

that are academic expect to learn details around how a study was conducted, and about the decision points in the interpretive process that led to particular conclusions and not to others (Reissman, 2008). For this reason, field notes were taken throughout the process. Chapters 3 and 4 include detail on the data analysis techniques used.

Ethical Considerations

Approval and Informed Consent

The Tri-Council Policy Statement: Ethical Conduct for research Involving Humans (2010) outlines considerations and limitations for studies such as this one. Three core principles provide the basis for the guidelines and policies developed by the Tri-Council, which are: respect for persons, concern for welfare, and justice. Extending from these are the pragmatic concerns of perceived coercion, dual relationships, and power. Further delineation of these principles includes acknowledgement that these three are interdependent and complimentary and that the application and weight of each is dependent upon the nature and context of the research at any given time. Ethical approval was obtained for this study from a University Human Subjects Research Committee.

Maintaining confidentiality and providing privacy throughout the process was considered and maintained within the boundaries of the Tri-Council guidelines. Lin (2009) indicated security and data management in qualitative research deserves researchers' attention and is a critical process. Furthermore she indicates that data management encompasses topics including data storage and record keeping, data sharing, data ownership, human subjects' protection, and confidentiality. I have attended to each of these areas throughout the process of the research study.

I obtained informed consent prior to commencing the interviews. Participants were aware of the purpose of the study, potential benefits and risks, as well as, support available to them in this regard should the need have arisen. Furthermore, consent was obtained to digitally record the interviews (Appendix C). Further details are provided in chapters 3 and 4.

Findings

The final thesis consists of five chapters including the introduction and conclusion. The three chapters in between consist of articles on the topics of: “Moral Distress in Nursing: A Literature Review”; “Causes of Moral Distress in Emergency Department Registered Nurses”; and “Emergency Department Registered Nurses Reactions to Moral Distress.”

Chapter 2 - Moral Distress in Nursing: A Literature Review

Moral distress is an inevitable reality in healthcare. Due to serving all patient demographics exhibiting all types of conditions, emergency department staff need to understand all areas where moral distress has been studied. Understanding the history of the phenomenon chronologically and by data collection technique will provide context for the subsequent chapters on causes of and reactions to moral distress in emergency department nurses. This chapter will examine and summarize existing literature on the phenomenon of moral distress with a particular focus on the research that has contributed the most widely used instruments and accepted practices in the field in an effort to understand the existing knowledge and identify potential gaps. A broad range of scholarly references are cited in the text and presented primarily by data collection technique and chronologically as deemed appropriate. In addition, there is a brief section detailing the closely related topics of stress and burnout as they relate to emergency department nurses.

Chapter 3 - Causes of Moral Distress in Emergency Department Registered Nurses

Causes of moral distress in nurses have been widely studied and reported in both qualitative and quantitative capacities. There is remarkable consistency indicated as the primary causes of moral distress in the literature, however, the areas of focus for researchers in this regard has been almost exclusively outside of the emergency department. Hamric, Borchers, and Epstein (2012) provide the most detailed breakdown of the causes of moral distress. They classify the causes as rooted in one of three areas, which are: clinical situations; factors internal to the provider; and factors external to the provider or situation. Chapter 3 includes further description of their findings.

The purpose of chapter 3 is to understand if the phenomenon of moral distress exists in emergency departments in Alberta and, if so, the causes of these experiences. Four major themes emerged from data analysis: (i) ‘it’s about time’, details experiences shared by all participants as they describe how times pressures caused by increasing patient volumes is causing moral distress; (ii) ‘futile care’, details the participants experiences of providing aggressive treatment to patients not expected to benefit from that care; (iii) ‘between a rock and a hard place’, describes decision making and choices in the emergency department and is further broken into three sub-themes. The themes are: triage, challenging physician decisions, and decisions around resources. Finally, (iv) ‘one stop shopping’, detailing participant descriptions of how the emergency department is used as a primary care clinic by many patients.

Chapter 4 - Emergency Department Registered Nurses Reactions to Moral Distress

Frequent and repeated exposure of the emergency department nurse to high acuity patients, chaos, overcrowding, unreasonable patient expectations, trauma and death can be emotionally draining and challenging (Dominquez-Gomez & Rutledge, 2009). Combining this knowledge with the causes of moral distress identified in chapter 3, one must examine and attempt to understand the responses and reactions of the nurses to these situations. Participants shared their thoughts on the ways in which they deal with morally distressing situations. It was indicated that the type of individuals who gravitate toward working in the emergency department share many personality traits. The purpose of this chapter is to understand the way in which registered nurses working in emergency departments respond or react to occurrences of moral distress.

There were three major themes evident at the time of data analysis. The first theme, 'It's not going to change anything,' details participants perceived lack of power, the system they work in, and the sense that there is nothing that they can do about moral distress and therefore why bother thinking about it. The second theme, titled, 'I love my job,' is about the passion emergency department nurses have for their position and the personality type of the emergency department nurse. The third theme, 'Deal with it,' details participants' means of dealing with moral distress.

Significance of the Study

Understanding the unique nature of the emergency department is paramount in interpreting the results of the study. The context within which the participants work is one of high acuity patients, overcrowded with a high degree of stress, and one that often sees untimely

movement of inpatients from an environment that relies on timely decision making and disposition. There are myriad sources of stress and disruption in the emergency department environment. Emergency department registered nurses faces several unique challenges daily, however, much of the data provided evidence of moral distress as rooted in similar scenarios as studies conducted in other areas of nursing. For example, futile care is commonly cited as a cause of moral distress in most areas of nursing. One notable difference in an emergency departments is that, by nature, emergency department staff are taught and encouraged to save lives and provide all manner of treatment to prolong life. There are several recommendations resulting from the study and all levels of staff are called upon to heed these suggestions. For frontline nurses, it is important that they arm themselves with knowledge to prepare for the inevitable moral distress that they will face. For managers, administrators, and organizations, taking action to mitigate the frequency and degree of moral distress faced by their nurses will improve both the culture and climate of their emergency departments. This call for additional support from organizations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2000; Elpern, Covert & Kleinpell, 2005; Pauly, Varcoe, & Storch, 2009; and Shorideh, Ashtorab, & Yaghmaei, 2012).

Chapter 2

Moral Distress in Nursing: A Literature Review

Moral distress is an inevitable reality in healthcare. Jameton (1984) defined “moral distress” as a phenomenon in which one knows the right action to take, however, institutional constraints make it nearly impossible to pursue the right course of action. The phenomenon has since been studied in many acute care service environments to better understand it and to contribute to the growing body of knowledge on the topic. This chapter will examine, summarize and critique existing literature on the phenomenon of moral distress. This will include a particular focus on the research that has contributed the most widely used instruments and accepted practices in the field in an effort to understand the existing knowledge and identify potential gaps. In addition, there will be a brief section detailing the related topics of stress and burnout as they relate to emergency department nurses.

Those approaching research from an emergency department perspective have an interest in knowing all areas of healthcare that have been studied related to moral distress due to emergency departments serving all ages and patient conditions. Examples of areas where the phenomenon has been studied include: surgery, palliative care, seniors living options, registered nurse anesthetists, general nursing practice (primarily overseas), oncology, haematology, Intensive Care Units (ICU), and neuroscience nursing. Pauly, Varcoe, and Storch, (2009) report moral distress research has focused on acute care or specialized areas of nursing practice such as nurse practitioners, perinatal nursing, and intensive care nursing. Lawrence (2011) studied moral distress in the neonatal ICU environment stating, “In this environment RNs begin to wonder whether it is appropriate to pursue such aggressive treatment when chances for intact survival are

dismal. Carried out by their own hands, perceptions of futile care contribute greatly to the development of moral distress” (p. 258).

Definitions

Understanding the definitions of moral distress is important as there is a possibility that individuals do not know that they are experiencing moral distress as they may not fully understand the concept (Austin, Lemermeyer, Golman, Bergum, & Johnson, 2005). Jameton’s (1984) definition of moral distress has remained relevant and applicable since its inception; however, many researchers and authors have modified or augmented this initial description without fundamentally altering the concept. Wilkinson (1987) defined moral distress as a “psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision” (p. 16). Zuzelo (2007) further developed Jameton’s conceptual definition to include two categories: initial and reactive moral distress. “These categories differentiated between the distress initially felt by professionals when confronted with institutional barriers versus the reactive distress experienced by the same people when they fail to act on their initial distress” (Zuzelo, 2007, p. 345).

In 2002, the American Nurses Association (ANA) defined moral distress as pain or anguish that comes from confronting a situation in which the person is aware of a moral problem, acknowledges moral responsibility and makes a moral judgment about the correct action, but due to perceived constraints, acts in a manner that is perceived to be morally wrong. This definition is more similar to Jameton’s (1984) original definition than that of Wilkinson (1987). Hanna (2004) openly challenged the traditionally accepted definition of moral distress. In her article, Moral Distress: The state of Science (2004) she indicates that “without an adequate

definition, moral distress can be unrecognized, yet have a silent, clinically significant impact on health” (p. 73).

The Canadian Nurses Association (CNA, 2008) refer to a number of terms in their 2008 Code of Ethics which “can assist nurses in identifying and reflecting on their ethical experiences and discussing them with others.” Examples of types of ethical situations outlined include: ethical problems, ethical (or moral) uncertainty, ethical dilemmas or questions, ethical (or moral) distress, ethical (or moral) residue, ethical (or moral) disengagement, ethical violations, and ethical (or moral) courage. Notably, CNA (2008) cite Fenton (1988), Jameton (1984) and Webster and Bayliss (2000) as contributing to their definition which was used throughout my study. CNA (2008) define moral distress as:

Ethical (or moral) distress arises 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 or prevent a particular harm. When values and commitments are compromised in this way, nurses’ identity and integrity as moral agents are affected and they feel moral distress. (p. 6)

Following years of focus on the frontline clinicians and their experiences of moral distress, McCarthy and Deady (2008) challenged the traditional scope of moral distress. This research led them to call for a review of additional research approaches to moral distress and a possible redefinition of the phenomenon. They concluded that both qualitative and quantitative approaches have left the definition and experiences of moral distress inadequately researched and without sufficient description. It is evident that there is still room for additional development in the theoretical components of moral distress that have been noted here, as well as, the need for

research in other clinical areas such as the emergency department. In fact, just one published research study article on moral distress related specifically to emergency departments was located in the literature with one additional article found describing the role of moral distress in trauma nursing. One auto ethnographic study conducted by a registered nurse in Australia, as part of her doctoral thesis work, was located, however, the applicability to Canadian emergency department registered nurses is uncertain.

Data Collection Techniques

An examination of the quantity of citations found in the literature indicates that there have been more quantitative studies of moral distress than qualitative. However, corresponding with this are the natural progression through specified periods of time in which the research is completed. For example, in the 1980s all of the published work was qualitative while the development of a Moral Distress Scale (MDS) by Corley in 1995 resulted in a large amount of quantitative studies being published in subsequent years. By 2005, mixed methods were being utilized frequently, offering the benefit of results based on use of both methods.

Qualitative Studies

In its infancy, moral distress was conceptualized and defined by Andrew Jameton (1984). This genesis was followed by the work of Wilkinson (1987) who studied and published on the experience and effects of moral distress in an effort to generate a model of the moral distress experience. She indicates that although there was no data connecting the experience of moral distress directly to patient care, a connection can be inferred. As a pioneer in this area of study, Wilkinson's (1987) research was undertaken primarily "to generate substantive theory about the relationship between moral aspects of nursing practice and quality of patient care" (p. 16). A survey approach was utilized for the study and the results laid the foundation for many

researchers who have followed. Results of this initial study were presented as a narrative description of moral distress with frequency tables quantifying the data. The author does indicate that a disproportionately high number of Intensive Care Unit (ICU) nurses were represented and commented that these particular registered nurses “were sincere, thoughtful, credible, and aware of the moral issues of their practice” (Wilkinson, 1987, p. 20).

Wilkinson (1987) developed a Moral Distress Model which incorporates triggers and responses to morally distressing situations which is overlaid with the visual aid of four parameters. These parameters are situation, action, cognition, and feelings. The model is based upon her survey findings and appears as a visual aid in the article in the form of what would today be referred to as an algorithm. Wilkinson (1987) concluded with some implications for nursing practice including that nursing administrators must provide higher degrees of support in moral situations. She detailed that nurses who do not receive sufficient support will leave the area they work in if not the field of nursing altogether. The call for additional support from organizations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2001; Elpern, Covert, & Kleinpell, 2005; Pauly, Varcoe, Storch, et al., 2009; and Shorideh, Ashltorab, & Yaghmaei, 2012).

Another implication identified in Wilkinson’s study is the need to incorporate additional nursing ethics education in curriculums, and finally, a call for more research “to better saturate the categories developed in this study” (Wilkinson, 1987, p. 28). Wilkinson’s study was the first of its kind and remains the cornerstone of moral distress research. Several terms have changed since that time, however, subsequent research continues to support the findings of this landmark study. For example, Millette (1994) qualitatively studied the moral choices and ethical decisions of nurses as they affect patients’ care. She utilized Carol Gilligan’s

(1977, 1979, 1981, 1982a, 1982b) framework to study nurses' stories of moral choices. One significant difference from the original work of Wilkinson (1987) is that Millette (1994) provided a semi-structured interview format which clearly facilitated elaboration and explanation which would not have been possible with Wilkinson's (1987) method. In this case, an effort was made to classify nurses as coming from either a caring or a justice orientation with results indicating, "neither orientation seems to be more effective in assisting nurses in making moral choices" (Millette, 1994, p. 672).

Also in the ICU environment, the first study of moral distress in the country of Iran was conducted utilizing a qualitative method involving semi-structured, in-depth interviews of ICU nurses (Shorideh, Ashktorab, & Yaghmaei, 2012). Despite failure to provide a specific purpose or intent statement, the analysis produced four themes to describe nurses' moral distress. These themes each fall in line with studies completed elsewhere in the world, they are; (i) institutional barriers and constraints, (ii) communication problems, (iii) futile actions and medical/care errors, and (iv) inappropriate responsibilities, resources, and competencies. Less similar to research completed elsewhere are the twenty subthemes identified by the authors in this study that was limited to just 31 participants. The researchers indicate three of the subthemes are similar to Turkish studies in identifying the problematic issues of insufficient human resources and equipment, poor job motivation, and lack of time.

Furthermore, Shorideh, Ashktorab, and Yaghmaei (2012) recommended that managers "develop and design clear job descriptions for nurses" (p. 476), implying that there are no or limited existing job descriptions at the 12 hospitals that were used in the study. Finally, there is a call to improve decision-making strategies, design strategies to reduce conflict-causing conditions, improve decision-making strategies, and "try to diminish moral distress factors" (p.

476) without specific discussion in the article which relates the recommendations to the findings. The information from this study does not increase the body of knowledge on moral distress for areas outside of where the study occurred. It does, however, re-iterate the existence of challenges faced elsewhere in the world.

In another qualitative study from overseas, Maluwa, Andre, Ndebele, and Chilemba (2012) aimed to explore the existence of moral distress among nurses in the Lilongwe District of Malawi. The researchers used a holistic and naturalistic approach with an open-ended interview guide that “allowed exploration of meanings and gaining of insight into the little known situation of moral distress” (p. 197). In context, this is meaningful and applicable, however, the method does not readily enable replication or lend itself to applicability outside of the immediate study area. The challenge with inability to replicate is that findings indicating, “results show that nurses, irrespective of age, work experience and tribe, experienced moral distress related to patient/nursing care” (p. 196) are less generalizable than studies using validated tools. Creswell (2007) indicated that one weakness with open-ended interviewing is the difficulty related to coding the data. Levels of moral distress were not examined resulting in less contribution to the body of knowledge than if a quantitative element had been paired with the “interview guide” that was used. This study was the first of its kind in Malawi which assisted the researchers to probe gradually and carefully into this topic. The strength of this research is in the foundation for future “awareness creation among all stakeholders in Malawi” (p. 206).

Range and Rotherham (2010) hypothesized that nursing experience and/or training may lead nursing students to “have less moral distress and more favorable attitudes towards a hastened death compared with those preparing for other fields of study” (p. 225). They found that there was no significant difference between nursing and non-nursing students on either

moral distress or attitudes towards a hastened death. Limitations for the study included having participants from a small, predominantly Catholic liberal arts college where students with a Catholic religious background reported having significantly more moral distress than those who reported other religious backgrounds. Another limitation was the non-random nature of the study, resulting in conclusions that are not generalizable.

One strength of this study was the finding that age and experience make no significant difference in the experiences of moral distress. This finding is consistent with Corley, Minick, Elswick, et al.'s (2005) research but directly opposed to the findings of Elpern, Covert, and Kleinpell (2005) who found that "moral distress was significantly correlated with years of nursing experience" (p. 523). Notably, all three of these studies used Corley's (2005) Moral Distress Scale (MDS) in various forms as a part of their data collection. The difference in the use of the MDS involves the number of questions used. For example, Elpern, Covert, and Kleinpell (2005) used a 38-item MDS while Range and Rotherham (2010) used a 30 item MDS-R, due to, questions unrelated or inapplicable to their study being eliminated from the modified 38 item MDS scale. Elpern, Covert, and Kleinpell (2005) studied nurses in a Medical Intensive Care Unit while Range and Rotherham (2010) studied nursing students.

Mitton, Peacock, Storch, Smith, and Cornelisson (2010) studied the phenomenon of moral distress as it relates to nursing managers using a qualitative approach of "thematic content analysis guided by constructivist principles." According to Green and Thorogood (2004) this is an appropriate approach given the circumstances of being an early attempt to investigate a relatively new topic. The topic of moral distress is not new, however, studying it from a managerial perspective identifies it as a new focus. Their results suggest that moral distress is

not unique to clinical staff but impacts managers as well. This research is particularly applicable to researchers who are in managerial roles or supervise others, such as charge nurses.

Gilligan's (1977) belief that moral decisions are "insistently contextual" (p. 482) and that individual's reasoning and processes can be best understood when the person describes a personal experience is a common theme throughout the qualitative literature on moral distress. Wilkinson's (1987) Moral Distress Model remains the cornerstone for subsequent research on the phenomenon.

Quantitative Studies

Wilkinson's (1987) research was the impetus for the development of the quantitative Moral Distress Scale (MDS) developed and evaluated by Corley, Elswick, Gorman, et al. (2001). The MDS consists of 32 items in a 7-point Likert format; with a higher score indicating a higher level of moral distress. The framework guiding the development of the MDS, which occurred from 1994 to 1997 included House and Rizzo's (1972) role conflict theory, Rokeach's (1973) value theory, and Jameton's (1984) conceptualization of moral distress. Items included in the MDS were developed from existing research on moral problems that nurses face in hospitals. A two-stage process was used to verify content validity (Corley, Elswick, Gorman, et al, 2001).

Firstly, research findings on moral problems in hospital settings resulting from institutional constraints were identified for domain identification. In total, 32 items on a 5-point response format were identified to reflect moral problems in the MDS. Secondly, Wilkinson (1987) and Jameton (1984) were consulted to clarify the concept of moral distress. The MDS was then assessed for content validity by three experts in nursing ethics to ensure all items were relevant.

Instrument testing included three stages: test-re-test, known groups, and administration of the instrument to a sample of 214 nurses. In the test-retest stage, it was revealed that there was limited variability in responses which led to the scale being expanded from 5 to 7 items (little/almost none 1 to great 7). The second step involved using a contrasting groups approach whereby occupational health nurses and a group of critical care nurses completed the MDS. The occupational health nurses did not identify items on the scale as causing moral distress although they identified themselves as experiencing moral distress related to other problems. The critical care nurses identified moderate to high levels of moral distress related to the situations identified in the MDS (Corley, 1995). In the third stage, five groups, three of them from critical care areas, completed the instrument as a random sample with both descriptive and factor analysis conducted on the data. The possible range for scores was 1 to 7 with a higher score indicating a greater level of moral distress. The mean scores by item ranged from 3.9 to 5.5, indicating moderately high levels of moral distress. Notably, “none of the demographic variables (age, education, gender) or work experience variables (work setting, years as a nurse, years in current position) predicted the levels of moral distress” (Corley, Elswick, Gorman, et al, 2001, p. 254). Furthermore, previous resignation from a nursing position, due to moral distress, did not predict current levels of moral distress.

Corley, Elswick, Gorman, et al. (2001) indicated that their testing of the MDS revealed evidence of reliability and validity with acknowledgement of the need to test further with larger sample sizes to enhance the instrument’s validity and reliability. They also recognized the need for other instruments that measure moral distress for other groups of nurses who work outside hospital settings. The rigorous and robust work of Corley, Elswick, Gorman, et al. (2001) has proven to be the gold standard in measurements of levels of moral distress for nurses in hospital

settings. Their work is cited in virtually every peer reviewed article written after 1997 that was specific to moral distress located for this paper. The only competing sentiment discovered in the literature was from Zuzelo (2007) who indicated that some respondents in her mixed methods study “found the MDS instructions difficult to comprehend” (p.357).

Subsequent to the publication of the Development and Evaluation of a Moral Distress Scale (Corley, Elswick, Gorman, et al. 2001) four other instruments have been identified in the literature as developed and tested. The results and applicability of these more recent tools is varied.

Hamric and Blackhall (2007) shortened the MDS to just 21 items to focus on end of life issues in ICU environments. Hamric, Borchers, and Epstein (2012) indicated that this was necessary as the 38 item MDS was simply too long to be used in multivariate studies. In 2012, the MDS was revised to become a 21 item instrument which uses a 0-4 scale (Hamric, Borchers, & Epstein, 2012). The quantitative measurement of the MDS-R, unlike the MDS, includes questions related to pain management and competence of healthcare personnel. The researchers had three purposes for revising the MDS: to make it more inclusive of root causes of moral distress; to expand its use into non-ICU settings; and to make it useable for multiple healthcare disciplines.

Olson’s Hospital Ethical Climate Survey (HECS) is a 26-item scale designed to assess nurses’ perceptions of the ethical climate of their workplace (Olsen, 1998). It was used to develop this revised instrument and similar to the original MDS, the results are well validated. Hamric, Borchers, and Epstein (2012) who developed and tested the MDS-R, indicated that initial testing involving physicians and nurses showed that the tool demonstrated that nurses in the eight ICU’s tested experienced significantly higher levels of moral distress than physicians at

the same facilities. Furthermore, they reported that there is a negative correlation to the ethical climate for both groups.

Sporrong, Hoglund, and Arnetz (2006) developed the Moral Distress Questionnaire (MDQ). It is an instrument used to measure everyday moral distress in healthcare settings. Only one other example of use of this tool was located in the literature which is discussed in the mixed methods section of this paper.

The Moral Distress Scale for Psychiatry (MDS-P) was developed and presented by Ohnishi, Ohgushi, Nakano, et al. (2010). It is a tool that is clearly specific to registered nurses involved with care for those with mental health concerns. One strength of the instrument is the specificity of measurement as the tool can be used in any mental health setting. Similar to the MDS, the MDS-P provides valuable data about frequency, type and intensity of moral distress but fails to provide emotional and behavioral impacts to registered nurses.

These validated tools continue to be used in a variety of treatment settings with quantitative results largely focusing on the causes and levels of moral distress. Several authors have indicated that moral distress in the Intensive Care Unit has been studied more than any other area of nursing. Other contributors on the topic of causes and levels of moral distress in an ICU environment include Wiegand and Funk (2012) who studied causes while Elpern, Covert, and Kleinpell (2005) studied levels finding moderate levels similar to that of Corley, Elswick, Gorman, et al. (2001).

Mixed Methods

Following the work of Corley, Elswick, Gorman, et al. (2001), there was adequate instrumentation available for researchers to use mixed methods approaches to provide knowledge and results in response to calls for outstanding questions in both qualitative and

quantitative realms. If the number of publications on the topic of moral distress is any indication, awareness of the topic and the overall body of knowledge has increased exponentially in recent years.

Elpern, Covert, and Kleinpell (2005) conducted a descriptive, questionnaire study in an effort to: evaluate associations among moral distress and individual characteristics of nurses; explore implications of moral distress; identify situations that result in moral distress; and to assess the level of moral distress of nurses in a medical ICU. They list moral distress as contributing negatively to job satisfaction, retention, physical and psychological well-being, spirituality and self-image. Maiden, Georges, and Connelly (2011) acknowledge this research and go one step further by including medication errors as resulting from moral distress.

Elpern, Covert, and Kleinpell (2005) also found that the highest levels of moral distress occurring in medical ICU nurses was in instances where aggressive treatment was provided to those not expected to benefit from the treatment, also known as futile care. They report the frequency of moral distress in critical care environments as common. The results of this study are widely applicable to other ICU's and to nursing in general.

A correlational mixed methods design was utilized by Maiden (2008) to find statistically significant relationships between moral distress, compassion fatigue, and perceived medication error. Most notable is the instrumentation used for this work which includes: Corley's 2005 Moral Distress Scale (MDS), Professional Quality of Life Scale (ProQOL), and the Medication Administration Error Scale (MAE). While the study attempted to correlate several aspects of care, the results indicated that the greatest benefit was the better understanding of critical care nurses insight regarding medication error and power relations while simultaneously promoting

the need for organizations to build work cultures where error reporting is commended, instead of punished.

McLendon and Buckner (2007) sought to describe levels of moral distress in critical care environments using a mixed methods approach in an ICU setting, the effects of the distress on their personal and professional lives, and nurses' coping strategies. The researchers combined a subjective, open-ended questionnaire with the MDS (Corley, Elswick, Gorman, et al., 2001) to yield quantitative results consistent with those of Corley, Elswick, Gorman, et al. (2001) and other researchers which indicated that this group of critical care participants experienced moderate levels of moral distress. From a qualitative perspective, McLendon and Buckner (2007) recommended efforts be made to reduce critical care nurses stress in an effort to recruit and retain their experience.

One mixed method study indicated that participant suggestions included utilization of debriefing sessions as vehicles for enhancing ethical understanding and problem solving, as well as, incorporating ethics rounds and discussion groups into their work (Zuzelo, 2007). This recommendation is supported by Huffman and Rittenmeyer (2012). The credibility of Zuzelo's study is enhanced by her use of a quantitative, descriptive study methodology, incorporating the original, validated 32 item MDS and open-ended questions to elicit data. Zuzelo's narrative data was analyzed thematically resulting in 7 broader topics. Notably, three of the seven topics center around moral distress as it relates to an aspect involving physicians. Corley, Elswick, Gorman, et al. (2001) noted that nurses are in the challenging position of having more responsibility than authority, which can result in their being unable to fully realize their full scope of practice, and confuses their sense of right and wrong. Examples of this are frequently seen in emergency

departments when, for example, from the nursing perspective, physicians under prescribe analgesics to those in acute pain or overprescribe narcotics to those in palliative care situations.

Further support of this notion is found in Walker's (2003) *Moral Contexts*, from a feminist perspective, which gives information about the concept of an alternative moral epistemology that views moral knowledge as inseparable from social knowledge. Two facts she re-iterates are: 1) that social hierarchies ascribe inferior positions to some of their members; and that 2) social orders differentiated by power and status (i.e. by class, race, age, sexual practices, gender, education, professional role, etc.) are the rule rather than the exception in human societies.

A potentially less applicable mixed method approach was used by Eizenberg, Desivilya, and Hirschfield (2009) when they applied the MDQ developed by Sporrong, Hoglund, and Arnetz (2006) and combined it with five focus groups for each participant to find that "conflicting perceptions between staff (between nurses and physicians, or between staff nurses and nurses in supervisory positions) contributed to moral distress" (p. 887). What makes this less applicable is the context. The results are from an Israeli community with the qualitative component of the study focusing on the Jewish and Moslim heritage of the participants. More relevant findings of the study, which state that time constraints and shortages of resource are sources of moral distress, are supported by a number of studies (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Glasberg, Eriksson, Dahlqvist, et al., 2006; Redman & Fry, 2000; Zuzelo, 2007).

I come from an emergency department environment and, very surprisingly, I located only one research study of moral distress in emergency departments, done by Fernandez-Parsons, Rodriguez, and Goyal (2013). They used a quantitative, cross-sectional, descriptive design to

study moral distress in emergency department nurses. Using a 21 item Likert-type of questionnaire, they assessed the intensity, frequency, and type of moral distress that the emergency department nurses are experiencing at one community hospital. There were 51 participants with results indicating an overall low level of moral distress. The three situations reported to cause the highest levels of moral distress were providing futile care, concerns related to the competency of health care providers, and diminished quality of patient care related to poor team communication.

The purpose of the article, Moral Distress: An invisible challenge for trauma nurses, is to describe the role of moral distress in trauma nursing and arguing for more research to be completed “to identify critical intersections in the trauma nurses life” (Hamilton-Houghtailing, 2012, p. 236). Hamilton-Houghtailing identified the gap in current literature about the understanding of moral distress by trauma nurses. They indicated that focusing on moral distress could provide these nurses with an ability to articulate the emotional process and stages they experience when faced with morally challenging patient dilemmas. For example, she indicated that nurses are expected to maintain emotional control and professional proficiency while performing painful procedures, as well as bearing witness to their patients’ personal crises, all while facing death and mayhem. Using two case studies to illustrate common trauma nursing scenarios, Hamilton-Houghtailing effectively introduces the reader to the phenomenon of moral distress and challenges researchers and organizational leaders to acknowledge and understand moral distress as a first step toward altering suffering into compassionate action.

Stress and Burnout

Many healthcare professionals have reported that the emergency department is the most stressful environment in hospitals. Karr (2006) reported that emergency room nurses work in an environment that is volatile and challenging due to frequent exposures to critical incidences and stressful events. High patient volumes and high acuity contribute to this stress which may contribute to emergency department nurses being highly susceptible to burnout. Stress and burnout are not synonymous. Espeland (2006) indicated that stress itself is a neutral event and that it is up to the nurse to interpret the stress as being positive (helpful) or negative (unhelpful). Furthermore, she indicated that burnout produces a sense of helplessness or hopelessness while stress can produce energy and urgency.

Roach (1994) reported that job stress may be the result of role overload. Role overload is a condition defined as, “where the employee experiences too many demands in terms of both time and duties” (Roach, 1994, p. 42). Emergency department nurses are susceptible to role overload which is an element that may lead to burnout. In order to prevent the occurrence of burnout, it is imperative that nurses are cognizant of both the causes and symptoms of burnout (Espeland, 2006). Burnout develops gradually and progressively worsens as a result of daily stress, emotional exhaustion, and a reduced sense of accomplishment. Symptoms of burnout include illness, fatigue, cynicism, anger, disillusionment, difficulty sleeping, and a sense of helplessness and hopelessness (Hooper, Craig, Janvrin, et al., 2010). As reported by Vahey, Aitken, Sloane, et al. (2004), nurse burnout is a significant factor influencing how satisfied patients are with their care. Furthermore, they report that negative health outcomes for nurses related to burnout include somatic complaints, psychological distress, as well as alcohol and drug abuse.

Hooper, Craig, Janvrin, et al. (2010), who compared patterns of compassion fatigue, burnout, and compassion satisfaction in emergency nurses with nurses in other specialty areas, concluded that emergency nurses with higher compassion satisfaction tend to have lower burnout levels. The investigators found lower levels of compassion satisfaction in emergency nurses than in other specialty areas, such as the Intensive Care Unit, which may result in less pleasure in their ability to care for others and to contribute to the workplace and society. Notably, they found that over 80 percent of emergency nurses experience moderate to high levels of burnout with 86 percent expressing some degree of fatigue.

The emergency department offers a unique set of stressors that can have negative impacts on nursing staff. For example, overcrowding of patients, pressures to improve turnaround times, delays in assignment of inpatient beds, and other factors distinctive to this environment (Hooper, Craig, Janvrin, et al., 2010). The literature indicates that stressful events are common in emergency departments and that the effects can be profound on staff, who are often ill prepared to cope with them (Healy & Tyrrell, 2011). In an Australian study, violence against staff, followed by heavy workload, and inappropriate staff mix were reported to be the greatest stressors for emergency department nurses (Ross-Adjie, Leslie, & Gillman, 2007). Jonsson and Halabi (2006) found matters of death and dying, as well as, dealing with doctors to be the most stress inducing events in emergency department nurses. Laposia, Alden, and Fullerton (2003) found that interpersonal conflict is associated with Post Traumatic Stress Disorder among emergency department staff surveyed at a Canadian hospital.

Somewhat ironically, the most notable gap in the moral distress literature falls in an area so closely related to the most studied area, the Intensive Care Unit (ICU), that it is difficult for

those in emergency departments to understand why. Further research to understand registered nurses experiences of moral distress in emergency departments cannot be delayed any longer.

Chapter 3

Reasons Emergency Department Registered Nurses Experience Moral Distress

Moral distress is an inevitable reality in healthcare. The phenomenon has been studied in many acute care service environments in order to better understand and contribute to the growing body of knowledge on the topic. Understanding the definition of moral distress is important as there is a possibility that individuals do not know that they are experiencing it due to not fully understanding the concept (Austin, Lenermeyer, Golman, Bergum, & Johnson, 2005). The Canadian Nurses Association (CNA, 2008) defined moral distress as:

Ethical (or moral) distress arises 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 or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress. (p.6)

Fry, Veatch, and Taylor (2011) identify five factors supported in the research literature which compromise nurses' integrity; they are: inadequate staffing, lack of administrative support, power imbalances, disrespectful communication, and institutional policy. Nurses with adequate moral agency including strong leadership and management competencies and virtues like courage have been identified as taking on their employing institutions and partnering to improve outcomes for all (Fry, Veatch, & Taylor, 2011).

Hamric, Borchers, and Epstein (2012) outline three categories of "root causes" (p.3) of moral distress. The first being clinical situations which includes; prolonging the dying process through aggressive treatment, disregard for patient wishes, providing inadequate pain relief,

providing false hope to patients and families, and providing unnecessary/futile treatment. The second is factors internal to the provider including; perceived powerlessness, self-doubt, inability to identify ethical issues, lack of understanding the full situation, and lack of assertiveness. The final category is factors external to the environment or situation and includes; lack of collegial relationships, lack of administrative support, tolerance of disruptive and abusive behavior, policies and priorities that conflict with care needs, and hierarchies within the healthcare system.

Pauly, Varcoe, and Storch (2009) report moral distress research has focused on acute care or specialized areas of nursing practice such as nurse practitioners, perinatal nursing, and intensive care nursing. Intensive Care Units/Critical Care Units are identified as having nurses who display high levels of moral distress (Corley, Elswick, Gorman, & Clor (2000); Shorideh, Ashktorab, & Yaghmaei (2012); and Elpern, Covert, & Kleinpell (2005)).

Elpern, Covert, and Kleinpell (2005) indicate moral distress is a “serious problem among nurses, particularly those who practice in critical care” (p.523). However, the most closely related specialty area in all of nursing, the emergency department, is virtually absent from the literature on the topic of moral distress. The emergency department is a dynamic area that necessitates staff and physicians’ care for patients who present with myriad complaints and conditions across their entire life span. The registered nurse who chooses to work in this specialty area expects to be challenged at all times and understands that “time is king” in this area. Literature on patient conditions presenting to ED include slogans such as: Time is Muscle concerning myocardial infarctions (Antman, 2008), or Time is Tissue when referring to stroke (Morgan, 2014). Emergency department staff must think, speak, and work in terms of minutes and hours as opposed to other areas of nursing where plans are made and care is often planned and provided based on days and weeks.

Performance measures, or targets, in the healthcare system throughout the province are established by the government. The targets established for emergency departments revolve around time-based measures. There have been newspaper headlines in the province related to emergency departments focus on provincial performance measures including: “wait times,” “time to physician” (describing the time of arrival until patients are seen by a physician), or the length of time from admission to actually moving from the emergency department to an inpatient unit. The targeted time for patients to be seen and discharged home from the emergency department is four hours, while for those admitted to the hospital the targeted time is eight hours. According to Knapman and Bonner (2010), to recognize the multifactorial aspects of waiting times and the importance of efficiency in all aspects of care is to understand the environment and culture of emergency medicine.

Fernandez-Parsons, Rodriguez, and Goyal (2013) provided one of the few studies specific to moral distress in emergency departments. Emergency nurses reported low levels of moral distress in that environment which is inconsistent with other acute care areas studied which suggest moderate and high levels of moral distress. They used a quantitative, cross-sectional, descriptive design to study moral distress in emergency department nurses. Using a 21 item Likert-type of questionnaire, they assessed the intensity, frequency, and type of moral distress that emergency department nurses are experiencing in one community hospital. They reported that emergency nurses “spend much less time with each patient compared with other settings such as the intensive care unit, where the patient stays for days, not hours” (p. 550). Therefore, qualitative research is needed to understand if the phenomenon of moral distress exists in emergency departments in Alberta and, if so, the causes of these experiences. The purpose of this study is to explore this issue.

Methods

Research Design

A narrative inquiry research design was used to explore registered nurses narratives on sources of moral distress while working in emergency department settings. Narrative inquiry involves determining common themes from stories collected to enable presentation of the findings in the context of which they were discovered. Reissman (2008) indicated:

the term narrative in the human sciences can refer to texts at several levels that overlap: stories told by research participants (which are themselves interpretive), interpretive accounts developed by an investigator based on interviews and fieldwork by observation (a story about stories), and even the narrative a reader constructs after engaging with the participant's and investigator's narratives (p.6)

Capturing detailed life experiences or stories of a single individual or the lives of a small number of individuals can best be achieved through a narrative inquiry (Reissman, 2008).

Understanding individual's experiences may include retelling a story and attempting to make a subjective experience objective, as well as constructing meaning from that experience. Narrative evokes emotion and emotion helps shape narrative. Emotion enhances our memory for experience and thus negative emotional experiences are more likely to be encoded and rehearsed through talking and thinking about experience (Rees, Monrouxe, & McDonald, 2013).

Sample and Setting

A non-probability sampling technique was used for the research study. Participants were recruited by e-mailing individuals who identified themselves as willing to be contacted for research purposes at the time of their annual registration with the provincial regulatory body for registered nurses. Once I received the e-mail addresses from the governing body, there was no additional involvement or endorsement on their part.

Participants were recruited from throughout the province of Alberta with the exception of the zone where I remain employed and was previously an educator at eight of the sites. Inclusion criteria included working as a registered nurse in an emergency department at least 30 hours per week for a minimum of 2 years. The purpose of including only those working at least 30 hours per week and for a minimum of 2 years was to ensure that all participants had been sufficiently exposed to an emergency department environment to understand the context of that environment. Further, many registered nurses work in an area in a casual or relief status without achieving a high number of hours experience in that area. Hence, the need to have a relatively high number of hours worked per week in the inclusion criteria. Those who responded to the e-mail invitation recruitment flyer (Appendix A) were sent a letter of invitation (Appendix B).

Ten females and two males were interviewed. Ten of the participants work in urban hospitals and two are employed in rural settings. Their overall nursing experience ranged from 8 to 36 years with emergency department experience ranging from 7 to 20 years. The participant demographic form is attached as Appendix E.

Data Collection

Interviews lasting 60 to 120 minutes were completed at a mutually agreeable time and location for each participant. The majority of the interviews were completed via Skype with others occurring face-to-face in a major urban city at the location of the participants choosing. Once I had reviewed, received consent and provided the CNA definition of moral distress to the participant, probing questions were utilized along with open-ended, non-directional questions from the semi-structured interview guide (see appendix D for interview guide). The questions were developed with the intention of eliciting responses related to work situations that applied to the definition of moral distress. “Field texts,” notes related to setting and context, as labelled by

Clandinin and Connelly (2000), were taken at the time of the interviews with simultaneous audio recording of all interviews. Consent for the same was obtained prior from participants (Appendix C). I entered the interviews with a strong knowledge of the general context the participants work in and a sound understanding of the nuances that are often present in that environment due to having several years of experience in various roles as a registered nurse in emergency department settings.

Data Analysis

I transcribed all of the interviews as recorded and applied the thematic analysis approach. The importance of context and “re-storying” of data at the time of analysis is evident throughout the literature on narrative inquiry. I was mindful of the caution from Liamputpong (2009), who warned that use of computer-assisted data analysis software increases the possibility of “fragmenting” textual materials as computer-assisted data analysis is so efficient that the researcher may analyze the data so quickly that the context may be lost. Therefore, I merely utilized QSR NVIVO 10 to enter and house the data, and then printed the data for manual analysis and coding.

I used inductive production of categories and themes to aid in the manual analysis process. I completed initial coding, marking and color coded highlighting of the text, by reading and re-reading the text, and then completed axial coding. As defined by Liamputpong (2009), axial coding is “the step that allows researchers to connect different codes identified in the initial coding into different categories and sub-categories” (p.135). The next steps included, relating theoretical ideas to the text, interpreting the text, and making interconnections between the codes. Finally, I made notes of the relationship between the codes, the research questions, and the literature, as presented throughout this chapter.

A number of steps were utilized throughout the study to ensure trustworthiness. Carlson (2010) defines trustworthiness as ensuring that data is ethically and appropriately collected, analyzed and reported. Elements contributing to trustworthiness include: audit trails, reflexivity, triangulation, thick and rich descriptions, and pre-determining narratives of final reports (Carlson, 2010).

Although some researchers believe narratives are invalid, rigor was maintained throughout the research process by upholding strict conduct and decisions. Regardless of rigor, some researchers believe narratives are invalid. Paley and Eva (2005) provided an example of this stating, “Sartre claimed there are no true stories” (p.94). This statement precludes any belief that stories can be proven true or false. Narrative, as narratives, relate a sequence of events, makes causal claims and can be tested. Narratives as story are organized in such a way as to elicit a particular effect, which can sometimes distract attention from, or even be mistaken for, the implicit claims about causation (Paley & Eva, 2005). The context of emergency department environments must be provided to aid in ensuring all writing and reporting related to the study is clear and transparent to the reader.

Ethical Considerations

The Tri-Council Policy Statement: Ethical Conduct for research Involving Humans (2010) outlines considerations and limitations for studies such as this one. Three core principles provide the basis for the guidelines and policies developed by the Tri-Council. They are: respect for persons, concern for welfare, and justice. Evolving out of these principles are the pragmatic concerns of perceived coercion, dual relationships, and power. Further delineation of these principles includes acknowledgement that these three are interdependent and complimentary and that the application and weight of each is dependent upon the nature and context of the research

at any given time. Ethical approval was obtained for this study from a University Human Subjects Research Committee.

I remained aware of the possibility of perceived coercion of the participants and excluded registered nurses who work in the zone where I work. As the manager of an emergency department, I had concerns regarding registered nurses in the immediate area feeling pressured to participate as they might think that it would affect current or future job prospects. Clandinin and Connelly (2000) indicate narrative researchers must consider their responsibilities from a relational perspective. Researchers will invariably find themselves in gray areas with the participants regarding the informed consent. “In much the same way that we consult our consciences about the responsibilities that we have in a friendship, we need to consult our consciences about our responsibilities as narrative inquirers in a participatory relationship” (Clandinin & Connelly, p.172). For these reasons, registered nurses working in the zone where I am employed were excluded from the study to ensure that there was no existing relationship, subordinate or otherwise, between the participants and me.

Maintaining confidentiality and providing privacy throughout the process was considered and maintained within the boundaries of the Tri-Council guidelines. Lin (2009) indicated security and data management in qualitative research deserves researchers’ attention and is a critical process. Further, Lin indicates that data management encompasses topics including data storage and record keeping, data sharing, data ownership, human subjects’ protection, and confidentiality. Each of these areas was attended to throughout the process of the research study. Guaranteeing anonymity in a meaningful way, as required by universities ethical guidelines, is a challenge according to Clandinin and Connelly (2000). They identify that ethical matters may change and shift as the researcher moves through the inquiry, resulting in a need to narrate

ethical matter over the entire narrative inquiry process. Ethical (internal and external) and political (external) barriers were minimized by ensuring anonymity and acknowledging all identified biases throughout the study. A pseudonym was chosen or assigned for each participant following their interview. The pseudonym was used at the time of transcription and for subsequent writing on the research study. Identifying information of the participants was removed from all transcripts, as well as all potential patient or location identifiers as noted by participants in such a manner that neither context, nor meaning were lost.

Informed consent was obtained prior to commencing the interviews. Participants were aware of the purpose of the study, potential benefits and risks, as well as, the availability of support should they need it. Consent was obtained to digitally record the interviews (Appendix C). All participation was voluntary and participants were made aware of their ability to drop out of the study at any time without consequence. Each participant received a \$10.00 gift card in recognition of their time and contribution to the study.

Results

Four major themes emerged from data analysis: (i) ‘it’s about time’, details experiences shared by all participants as they describe how time pressures caused by increasing patient volumes is causing moral distress; (ii) ‘futile care’, details the participants experiences of providing aggressive treatment to patients not expected to benefit from that care; (iii) ‘between a rock and a hard place’, describes decision making and choices in the emergency department. This theme is further broken into three sub-themes, which are: triage, challenging physician decisions, and decisions around resources. Finally, (iv) ‘one stop shopping’, details participant descriptions of how the emergency department is used as a primary care clinic by many patients.

Table 1 illustrates the four major themes with their definitions and sub-themes where applicable, described in detail in the following section.

Table 1

Unique causes of Moral Distress in Registered Nurses Working in the Emergency Department

It's About Time	Competing demands causing Registered Nurses inability to provide the care their patients need
Futile Care	Experiences of providing aggressive treatment to patients not expected to benefit from that care
Between a Rock and a Hard Place	Decision making and choices in the emergency department
-Triage	Triage decisions
-Challenging Physician Decisions	Challenging physicians orders and decisions
-Decisions around Resources	Use of human resources, treatment spaces and protocols
One Stop Shopping	Use of the emergency department as a family care clinic; Public education required

It's About Time

Every participant spoke of time pressures while working in the emergency department. The participants indicated that the constant influx of new patients results in morally distressing situations as they know what the right things to do for their patients are but are often unable to do so as they must move on to the next patient in the event that they are in greater need. This is problematic because in many instances the next patient has not yet been fully assessed or seen by

a physician. Sue indicated that high patient volumes limit the amount of time she is able to spend with her patients, while Ben described often “robbing Peter to pay Paul” when your section is full and then a sicker patient comes through the door. Rose indicated that nurses spend their time where they are needed most at that moment. The moral distress tends to come immediately after the flurry of activity of a resuscitation or after breaking devastating news to a patient when that patient or their family really needs you there for support, teaching, or explanation. Rose said:

And the time, five minutes later another IV need to be started and there's two nurses working with 12 patients. That sense that the goal is, here's a new patient and I don't know what's wrong with him, I have to move on to the next step. And I think that's a very telling example of what the CNA definition [of moral distress] is trying to address.

Sue commented that her inability to provide timely feedback to colleagues and the lack of time their team has to vent or share their frustrations with one another is related to time constraints.

As Sue stated:

There are a lot of situations where I wish I could mentor a co-worker through a situation because I look back at when I was in that situation and I could really have used someone to step in and listen and talk about it in the actual time it was happening. Say someone is dying or being particularly frustrating. Something is particularly frustrating with the patient and we don't have time to decompress or help each other through those situations.

Rose indicated that even though at one time there was time for more team decisions to be made, that was no longer the case. She said, “I have four patients at triage who all need a monitored cardiac bed and I don't have one... those kinds of team decisions and the burden of pressures are being forfeited by this time pressure.” Phil also spoke of the cumulative effect of

high patient volumes and the negative effect it has on his ability to spend time with his team.

Phil noted:

It's everything adding up. That if it was less busy, you would have these more or less clear cut cases and you would have more time, I feel like, to discuss amongst your colleagues. I think the busyness factor just takes away the ability to discuss amongst the team.

The concept of time constraints causing moral distress is woven throughout all of the themes. Participants continually described situations where they knew that what the right thing to do would be to spend more time with a patient or address a situation with another team member, but were unable to do so related to time pressures.

Futile Care

Participants expressed frustration surrounding futile care provided in emergency department settings. This care varied from patients palliating in the ED to patients seen immediately following a trauma, as well as, the associated public perception of what can be achieved in these scenarios. Participants know that the right thing to do is to be humane, yet they acknowledge that the focus in the ED environment is to prolong life.

Several participants mentioned instances of caring for palliative patients who presented to the ED seeking comfort measures but who were ultimately subjected to multiple invasive interventions. In many cases, this was due to unclear goals of care or an unwillingness on the part of the patients' family or the healthcare team to hold back on potentially physically and psychologically invasive interventions. Chloe gave an example of a time when she felt that they were actually torturing a patient by providing futile care:

I just felt sick, we put in a central line, a chest tube, all the poking and prodding. This poor man who didn't have long to live anyway, we were using all these resources to try and save him. I felt like it was torture.

In cases of trauma, participants expressed a similar generally accepted expectation of the healthcare team and patients families that every intervention is completed regardless of futility. There was speculation from some that this is related to the sudden and unexpected nature of the scenario. Others indicated that there is a correlation between the age of the patient and the length of time and invasiveness of interventions initiated. Participants relayed varying degrees of ease addressing the direction the care is taking while witnessing, or participating in, clearly futile efforts. Even participants with many years of experience remain uncomfortable addressing their concerns to the team. Sue, who has 7 years of emergency department experience, indicated she is still not at a point where she is comfortable asserting her concerns:

For example, if we are giving our fiftieth unit of blood to a patient who is going to exsanguinate [bleed to death] no matter what, and we feel like we are going to be unsuccessful, those times when everyone is looking around the room to see who is going to speak up.

Participants expressed concern around the driving forces behind the decision to maintain aggressive efforts in situations that are clearly futile. Examples of driving forces stated by participants include: legal considerations, from both police and physician perspectives, patients families wishes, and the healthcare teams desire to utilize their knowledge and skills. Phil indicated consideration for more comfort care scenarios would result in “less gawking,” “less intensity,” and “more dignity overall for the patient.” Phil described how futile care was provided to stabbing victims:

So, in those cases, it's typically younger people, they are involved in violence and they get stabbed, you're thinking they are probably going to die from these injuries, they're fatal injuries, so you know in these cases the whole world shows up...and eventually, it's we're gonna crack the chest and we're gonna try and save this guys life... you lose perspective and you've got to keep in mind that this is a person, you're doing something very, very invasive, and you could be doing something very painful. It could be very unsettling for them [the patient] and for their family to see this.

Participants identify unrealistic expectations of the public as contributing to the provision of futile care. Participants further identify television programs as glamorizing emergency departments and misleading the public to the point where some believe that patients can be brought back from the dead. Edna commented on this point indicating that:

I think to a large part it's propagated by the public whose expectations cannot be delivered... We really have given the public unrealistic expectations as to what we can do and can't. You know there's a lot more that comes in, there's media that comes into it where everybody is saved on television, it's amazing.

These expectations are evident in families of patients, as the participants described very tense situations, where patients are essentially no longer allowed to die.

Between a Rock and a Hard Place

This theme reflects making decisions in the emergency department. There are three sub-themes, they are: (i) triage, which describes the nurses' perception of an inability to get patients into a treatment space to be seen by a physician; (ii) challenging physicians decisions, which details addressing physicians' orders and directions that do not align with the nurses knowledge

and experience; (iii) decisions around resources, which describes the use of human resources, treatment spaces, and protocols in the emergency department.

Triage. Participants unanimously agreed that getting patients to a treatment space and closer to the point of physician assessment is both the goal of triage and a source of moral distress. Participants identify patients who are admitted to the hospital but are unable to move up to a ward, called Emergency In-Patients (EIP's), as problematic in all but one of the emergency departments represented. These EIP's negatively impact the triage nurses' ability to complete their work as efficiently and effectively as to which they intend. These so called "bed blockers" do not affect how the triage nurse "scores" the patient on arrival, however, they do impact the degree of moral distress the triage nurse experiences. Getting the patient to a treatment space to be assessed by the healthcare team is the right thing for the triage nurse to do. However, for many participants, physical bed management and working with staff who are less experienced are both prohibitive daily factors. Rose described how this scenario leads to moral distress in her area:

What happens on a busy night is that you at triage are really concerned about getting an assessment of this patient...you are putting them in an area that has less experienced nurses and the actual physical space is a chair, not a stretcher and these patients end up getting an NG tube inserted or given narcotics, within this space that was originally designed for less acute patients but ends up with sicker patients because we don't have the space available.

The Canadian Triage Acuity Scale (CTAS) is a tool used by triage nurses throughout the province to assist in the prioritization and sorting of patients. Unfortunately, this tool does not address the lack of treatment spaces required to accommodate the wide range of simultaneously

presenting illnesses experienced in the department. Several participants identified scoring patients using the CTAS, as “the easy part.” However, finding an appropriate location suitable to house the patient awaiting assessment and/or treatment, in addition to the challenge of being cared for in a timely manner, is an additional cause of moral distress for the triage nurse. When there are no vacant treatment spaces in the emergency department, the responsibility of managing patients awaiting care ultimately falls on the triage nurse. As a result, triage nurses’ frequently find themselves in situations where patients awaiting results are resting comfortably on a stretcher while acutely ill patients are awaiting assessment and treatment in the waiting room. Sue addressed this topic indicating:

The acuity in our department is incredibly high, sometimes you have 50 or 60 in our waiting room and we are completely overwhelmed...when we know there are people who need the bed more in our waiting room.

Among the challenges at triage is knowing which of the patients in the waiting room can actually wait to be seen. The triage score is a snapshot of the patient’s condition at the time of arrival and is subject to change. The triage nurse will often have several of each of the lower level triage scores in their waiting room and, at times, may have higher level triage scores in the waiting room for extended periods of time. In these situations, participants indicated their desire to empathize with patients and expressed their understanding of how this is frustrating for the patients. However, they also have to work within the physical constraints of their environment and this does not lessen their desire to provide a location for the patients to lie down. Rose, who worked in the ICU for 24 years before starting to work in the emergency department, indicated that working in the emergency department has the most situations of moral distress and that “triage is the most stressful role that I have ever done in my nursing career.” She gave an

example describing the moral distress that results when a patient's triage score may change suddenly, but that the system cannot accommodate it:

Like that patient that was actually a temporal artery stroke that you assessed as a migraine headache and sent to a chair that didn't really get an assessment for a couple of hours and fell having a seizure on the floor ... It's those things that happen in the moments like the seizure that brings everyone coming to their attention.

Another distressing scenario that occurs at triage is when patients overstate their concerns. Several participants indicated that they are frequently put into situations where there is incongruence between what they are being told and what the physical assessment and vital signs indicate. Christy indicated that no matter how much one educates the public that their situation may not be that serious, some people will not hear it. She stated: "It's tough for those who (incorrectly) think they are very sick...the triage nurse hears about it constantly." Christy went on to describe how patients think that they should be seen sooner than others, however, their condition does not warrant it and, "the public just does not care." These situations cause moral distress for triage nurses as they know that the right thing to do is to triage the sickest patients by triage score first. However, when they are misled by the patient, they are placed in a situation where the right thing to do is to take a lower acuity patient to a treatment space before one marked higher on the acuity scale. Lilly commented on the topic of incongruence between the patients' primary complaint and their physical presentation and vital signs while at triage. Lilly frequently experiences this challenge and gave an example of someone who complained of excruciating abdominal pain but could still eat Cheesies:

By and large, patients that cause this sort of distress are not sick...because [the patient] is coming in with a presenting complaint of 10 out of 10 abdominal pain but eating her

Cheesies, their presenting complaint increases their triage score. If we, say, start protocols based on triage scores, we would be over treating a fair portion of these patients.

Physician decisions. Many of the participants indicated that deciding when and how to challenge physicians' decisions is morally distressing in situations where the order or direction from the physician does not align with their knowledge or experience. Balancing patient advocacy and respect for those above them in the hierarchy were two considerations participants mentioned regarding addressing physician decisions. Several participants mentioned having to "know what you're talking about" when challenging a physician's order that you do not see as appropriate. Chloe spoke of trying to put herself in the physician's shoes and how she might react with a nurse questioning her decisions. She thought that she would rationalize the decision within the context of the situation but would also feel as if she was being undermined by someone lower on the totem pole and be defensive for that reason. She said in some cases, depending upon the personality of the physician, it came down to the physician not wanting to be seen as a "flip-flopper." Chloe described a situation where she felt that the right thing to do was to go back to the physician for a direct order when a patient discharge decision was left to her.

She stated:

It was an argument that ensued between a wife and this doctor and it was about a care situation...the wife felt her husband wasn't getting the care he needed. They had a very loud screaming match right outside of the patients room and the doctor just basically took off and left the decision up to the resident whether to discharge or not. And the resident was not a very strong individual in this circumstance so he left the decision to me whether to discharge the patient or not.

Chloe indicated the right thing to do would have been to approach the physician and request a specific order. However, in this case she wanted to know what the patient preferred so she could advocate but had difficulty speaking with the patient as tempers remained very high following the negative interaction.

Edna found herself in a morally distressing situation following her assessment of a nine month old child who had clearly been abused. Edna knew from experience that the child had been abused, however, the emergency physician who assessed the child indicated “the bruises” were Mongolian spots and discharged the child and her caregivers. Edna described the situation as follows:

A child who is totally flaccid, totally flat affect, not responding when you touch, blank stare. That is an abused child, you might as well have that tattoo on them. There were bruises everywhere and you get that really, really sick feeling...I called the doc right away. I called the police, child welfare, I did what I was supposed to do, I did my job. The doctor comes in, there were thumbprints on this kid, and says the nurse doesn't know what she is talking about, these are something called Mongolian spots.

The child was promptly discharged by the physician, which understandably put Edna in a great deal of moral distress.

Wendy described a situation where she was caring for a woman who was intubated (machine assisted breathing), was conscious, anxious, and had no orders for sedation. Wendy was unable to get a physician's order for sedation or an order for extubation (removal of the breathing tube). Wendy described the situation as that, “we were all in agreement that you don't

leave the patient in that middle ground, awake and intubated. You either have them sedated or you don't have them intubated."

Aliza commented on a scenario where there was a questionable physician's order. This caused moral distress, however, she and a colleague felt unable to speak with the doctor about it. Aliza summarized:

The doctor wrote a questionable order for an Amiodarone drip (anti-arrhythmic medication) and she was like, "I'm not going to talk to him about it, I'm going to wait for the next physician to come on. I don't want to deal with this doctor."

Aliza felt the right thing to do in that scenario would have been to address the physician, however, due to previous negative interactions with that physician, she understood her colleagues' decision to provide the medication according to the protocol and have the order changed later by another physician.

Decisions around resources. The participants identified an additional cause of moral distress that stemmed from decisions regarding allocation of human resources, treatment spaces, and protocols. Most participants indicated that they experience moral distress frequently related to the resources available to them. In most cases, they were referring to human resources in the form of registered nurses.

Participants overwhelmingly indicated that there is an insufficient number of registered nurses available to care for the number of patient visits in the emergency department. Many of them attribute this to the fact that many of the departments are seeing far more patients than for which they were designed. The result is that, in many cases, treatment spaces are being created

in areas that formerly housed supplies or had been hallway space. Ben, an emergency nurse for 7 years, indicated:

I can't remember the exact numbers they had set up for, but we are far surpassing these numbers [with] upwards of 250 people a day, that's two-fold what was expected for our staffing levels. The resources that we have are just not there.

Several participants stated that the right thing to do for their patients would be to simply spend more time with them. However, due to competing demands, they frequently find themselves having to complete the minimal amount to keep their patient safe and then move on to the next assessment, task, or physician's orders. Rose stated succinctly, "We can't tie an old man to a chair, keep the light on in emergency, give him the Morphine and call that good nursing care!"

Several participants indicated the right thing to do for patients would be to reallocate some of the existing resources to other healthcare areas. As patient volumes in emergency departments continue to rise, many participants describe working with higher staffing ratios than those who work in other care areas. Christy provided the most compelling argument when comparing resources dedicated to influenza prevention and the emergency department. She commented on the nurses who work on planning Influenza clinics, saying that: the wheel is reinvented every year instead of pulling out the binder, "blowing off the dust," and considering where the clinics were and how many staff were required. She went on to say:

They spend ten months of the year either doing, or planning Influenza... In emergency, those people are sick, you have a target to get them in and get them out in four hours unless you are admitting them... We're seeing all these ILI's (Influenza-Like Illnesses)

and these people are dying because they are sick but you walk into an immunization clinic and there are nurses sitting there twiddling their thumbs... eight nurses sitting there, two clerks, three o'clock in the afternoon, and the people coming into the Influenza clinic, they are well, they are ambulatory, there is nothing wrong with them, they are there to get an immunization. [My friend] it took him 20 minutes from when he walked in until he walked out and 15 minutes of that was waiting until your 15 minute assessment was up. I can't get (more) nurses for my patients who are having MI's and strokes, broken bones, and psychotic episodes.

Each of the participants work in emergency departments with a finite number of treatment spaces, not including temporary locations used for quick hallway assessments, ultrasound follow-ups, or other required expedient care. The participants all provided examples of instances where they were unable to place or move a patient to the most appropriate treatment space for a variety of reasons. In many instances, the patient was able to be located appropriately but not without considerable delays. Ann described an example where having half of their treatment spaces full with admitted patients (EIP's) who were unable to go to a ward and then having to see and treat 225 to 250 patients per day in less than a dozen treatment spaces. It is common for there to be delays related to this frequent scenario, but it also results in patients being seen and treated in areas that are not necessarily the most appropriate for them at that time. Jessica also described approaching the triage and charge nurses on multiple occasions to have patients moved from her unmonitored area into a more acute space as she simply could not provide the care the patient needed in that space. She described the scenario:

In our intake area, we have patients who are less sick and patients who are appropriate and those who aren't...I had to call back three times because they were sending me

patients who didn't belong there; they were too sick. So, finally the third time, I just said, "sorry, I am not comfortable having this patient here and you just have to move them."

Wendy spoke of the varying degrees of discomfort nurses have addressing their colleagues on the topic of treatment space allocation. She indicated that background and experience dictate comfort in caring for a higher acuity patient in a less acute space. She described a senior nurse who causes moral distress in the junior nurses:

We have one nurse and everyone in the department knows her for, "you only get a bed if you're ventilated, everyone else in a chair" ... some of the junior nurses find her verging on bullying if I can use that phrase. If she is at triage, she gets those patients out of the beds, "they can use a chair."

Ben spoke of frequent scenarios where he is put in a position of having to move patients to a more appropriate treatment setting and added that this is particularly problematic when a specific nurse is working. Ben described the right thing to do when he is unable to have a patient moved to a more appropriate treatment space:

Sometimes I just say, "I don't care, I need bodies in there, I need somebody doing charting, I don't care, I just need somebody." Depending who's in charge, it's more specifically just one nurse but she's in charge a lot and she will flat out say, "no." It's very, very dependent on who's in charge. Ben indicated that he and others ultimately share the burden of the moral distress or make an effort to pass it on to their colleagues in an effort to provide the care their patients need and deserve.

In addition to human resources and treatment space resources, all of the participants have access to resources in the form of guidelines and treatment protocols. All of the participants

work in emergency departments where there are guidelines or protocols that exist which permit them to initiate patient care on certain patients if specific criteria are met. The purpose of these protocols are to enable initiation of care earlier in the patient visit and to provide results to the physician prior to the physician seeing the patient. Half of the participants expressed these protocols as causing some degree of moral distress. The caveat with the protocols is that, if they are initiated, the nurse must complete all of the protocol as opposed to picking and choosing which parts of the protocol they would like to implement. The protocols were described by some participants as “not a shopping cart,” meaning that their educators had indicated, “you cannot pick and choose which parts you want to do, you do all of it or none of it.”

The reasons participants find the protocols or guidelines distressing is that, through experience, they know basically what the physician will order and the order may not necessarily correspond with the protocol. The most common example provided by participants was an Altered Level of Consciousness (LOC) protocol used in several urban emergency departments throughout the province. The Altered LOC protocol dictates that the nurse complete a drug screen, which is unnecessary according to some of the participants. Edna indicated that the context of where the patient lives and their medical history make many of the standing orders on the protocols unnecessary. Edna summarized: “I know why she is here and it is for a UTI (urinary tract infection), this is a grandma coming from a facility and she is not abusing drugs.” Several participants indicated that they do use the protocol as a shopping cart and further indicated that there is no negative consequence for doing this, “as long as you can justify it.” As an example, the chest pain protocol requires placement of an intravenous at 30mls per hour, however, Wendy stated, “They either don’t do anything or the doctor says give them a bolus. So it’s the bolus that happens.”

One Stop Shopping

Every participant expressed that they experience some degree of moral distress related to increases in patient volumes. Many of them indicated that this was due, at least in part, to patients' use of the emergency department as a family care clinic. Concerns ranged from inability to attend to the needs of the lower acuity patients in a timely fashion, to negatively oriented questions by nurses at triage in an effort to get patients to be seen elsewhere.

Several participants acknowledged that patients are not to blame for arriving in the emergency department with non-emergent presentations. Rather, participants repeatedly indicated that there is a lack of public education for healthcare consumers. Many believe that the public has unrealistic expectations and that the system created this by promising "absolutely everything." This includes promises for those new to Canada to which Edna said:

We're dealing with a lot of immigrant families who have absolutely no healthcare and no healthcare in their country of origin and they are told that health care is free which it isn't.

They just believe you access health care by going to the emergency department. You need to go out to the public and to educate the public that would relieve a lot of distress and a lot of people just by educating. We would not be put in that position. But it's not health care, not wellness care, it's sick care.

Participants also spoke of access and capacity challenges when patients choose to come or are sent to the emergency department. Lilly indicated that patients who are unable to get into a walk-in clinic or their family physician come to the emergency department. She elaborated indicating, "the booked procedures when a surgeon or a physician wants to do a mole removal. They don't have the supplies at their clinic so they come to the emergency department." Rose

clearly indicated that the right thing to do at the time the patient presents to emergency department is to get an idea of what is going on and “try to get a story.” However, she states that what happens is that patients are sometimes subject to negatively oriented questions that border on interrogation in an effort to send the patient to a waiting room, fast track area, or another health care facility. This causes moral distress in those who take a more compassionate approach to their work.

Phil spoke of how taxing it is on the healthcare system when patients are seen at an acute care location when they may be better served in primary care or, if they live in a facility, treated there (dependent upon the level of care offered at that particular facility). Phil felt that there needs to be more alternatives available for patients and their families outside of the emergency department. He explained his thought:

Sometimes I think primary care, more comfort care measures can be less demanding on a system, less demanding on staff, but better outcomes I think. Just kind of tying that to moral distress because acute care I find is driving you towards busyness and making hard, fast decisions, whereas primary care, also making hard decisions but more often the right decision and the best decision for the family.

All participants indicated that there are too many patients presenting to emergency departments and that many of them could be adequately cared for in an alternate health care setting. Ben was very direct with his assessment of this situation stating:

I do not think the government is doing enough to educate the public on proper use of emergency. There needs to be something in place which will penalize people for misusing emergency. We need to educate. I call [large urban city] hypo-copic now,

people do not cope and the first thing people do is come running to emergency for the silliest of things. Part of it is our doctors too, nausea and vomiting for two hours and we give them the Zofran instead of sending them home...Emergency is a one-stop shop now, you get your blood work, your radiology, and you get your results.

DISCUSSION

Limitations

One of the limitations to this study is that the findings are not generalizable. This is common in qualitative studies as they have very different purposes and strengths than being generalizable (Cresswell, 2013). The purpose of this chapter is to understand causes of moral distress in emergency department nurses in a single health region. Rural emergency department registered nurses represented just two of the twelve participants which led to results less representative of rural sites. While the sample size of 12 participants is appropriate for a study of a specialized area, there are thousands of emergency department registered nurses within the province which leaves the possibility that the findings are not representative of the larger demographic. More specifically, the relatively small representation of participants working in rural sites leaves the possibility that the findings do not represent the experiences of rural registered nurses as thoroughly as the urban participants that are represented. In addition, some potential participants may have opted not to participate related to the perceived normalcy of moral distress in their work environment or elected not to participate on account of perceived powerlessness to change the status quo. Others may have elected not to participate due to the potentially sensitive nature of the topic and concern for the emotion and impact the interview might have. The other notable limitation is that my life and work experience effect my perspective as the researcher. Despite my effort to be objective in the interviews and analysis, my background is implicated throughout the research process. The result of my involvement

leaves open the possibility that another researcher may have completely different findings from analysis of the same data.

General discussion

The first theme of, ‘it’s about time’ detailed participants’ inability to think about moral distress while working with time pressures. These time pressures to move on to the next task related to high patient volumes and acuity result in less time to interact with each patient, as well as, their colleagues to make team decisions. Participants reported that there was a time when patient volumes and acuity were lower. This allowed for time to address the right thing to do in those situations whereas now they describe moving very quickly on to the next patient or task. Fernandez-Parsons, Rodriguez and Goyal (2013), studied levels of moral distress in emergency nurses and reported low levels of moral distress in this area. They concluded that this is related to a relatively small amount of time spent with each patient. The participants in my study reported endless frustration related to their inability to spend more time with their patients. Time constraints have previously been reported as a contributing source of moral distress (Austin, Lemermeyer, Goldman, et al., 2005; Glasberg, Eriksson, Dahlqvist, et al., 2006; Redman & Fry, 2000; Sorlie, Kihlgren, & Kihlgren, 2005; Zuzelo, 2007).

The second theme of ‘futile care’ is consistent with other researchers’ findings, involving other acute care environments where nurses experience moral distress when providing care to those not expected to benefit from that care (Corley et al, 2001; Elpern et al, 2005; Shorideh et al., 2012). Participants expressed how the media perpetuates unreasonable expectations of what can be done to save lives. Furthermore, participants specifically identified patients receiving prolonged interventions, not thought to be beneficial following major multisystem trauma and palliative patients receiving a higher level of care on account of their families’ wishes, as causing

moral distress. Participants indicated that this care potentially causes physical or psychological distress in the patient receiving the care resulting in moral distress in the registered nurse.

Similar findings were reported by Lawrence (2011) in the neonatal ICU environment who stated, “In this environment RNs begin to wonder whether it is appropriate to pursue such aggressive treatment when chances for intact survival are dismal. Carried out by their own hands, perceptions of futile care contribute greatly to the development of moral distress” (p. 258).

There are three sub-themes within the theme called ‘between a rock and a hard place’ which reflects making decisions in the emergency department. The first sub-theme ‘triage’ outlines the causes of moral distress in triage nurses. Participants describe frequent delays in getting their patients to an appropriate treatment space in a timely manner. This is related to admitted patients remaining in the emergency department for extended periods of time and an overall lower number of treatment spaces than can accommodate the high volume of patients presenting to their departments compared to previous years. In addition to higher volumes of patients in recent years, participants describe overall higher patient acuity resulting in waiting rooms full of patients who may require physician assessment sooner than what the triage nurse is able to accommodate. The situation is further complicated in instances where patients overstate their concerns at triage causing additional moral distress.

The second sub-theme of ‘physician decisions’ describes instances where registered nurses face situations where they have an order or direction from a physician that is inconsistent with their knowledge or experience resulting in moral distress. Other researchers and authors have reported that the hierarchical nature of healthcare causes moral distress in nurses (Austin, Lemermeyer, Goldberg, et al., 2005; Elpern, Covert, & Kleinpell, 2005). Participants shared experiences of interacting with physicians who were unwilling to adjust their orders on due to

not wanting to be viewed as indecisive as well as physicians who dig their heels in when the nurse suggests an alternate order. Several participants also described the moral distress that they experience when they have to approach a physician due to receiving an order that does not align with the pharmacy monograph for the medication ordered or when they believe an order is simply not what is best for the patient based on their experience. Social hierarchies, such as those that occur in hospitals, assign inferior positions to some of their members and social order differentiated by power and status is the rule rather than the exception in human societies (Walker, 2003). It has been suggested that moral distress can never be completely eliminated (Fernandez-Parsons, Rodriguez, & Goyal, 2013; Walker, 2003). It is understandable how emergency department nurses have accepted that there will always be an element of moral distress in emergency departments related to the dynamic of physicians and nurses.

The third sub-theme called ‘decisions around resources’ focuses on decisions around allocation of human resources, treatment spaces, and protocols. Virtually all of the participants indicated that they work in emergency departments where there is an insufficient number of registered nurses available to care for the number of patient visits seen in their department. This is consistent with the findings of Corley, Elswick, Gorman, et al. (2001) who found that the highest levels of moral distress in those nurses working with a number of nurses so low that care is inadequate. Zuzelo (2007) identified that working with levels of nursing staff considered to be unsafe results in moral distress. Participants also described an inability to do the right thing when patients are seen and treated in a treatment space that is not ideal. For example, caring for a patient with cardiac complaints who is in an unmonitored area due to a lack of availability in a monitored area.

The other notable cause of moral distress related to resources mentioned by participants is related to use of treatment protocols. Several participants indicated that their educators had taught them that use of protocols is to be all or nothing. In other words, when a protocol is initiated, the nurses are taught that they may not use only the parts of the protocol that they deem to be applicable, but rather, they must apply all of the orders as indicated. This direction causes moral distress as several participants indicated that their experience has taught them use of all components of the protocols is unnecessary in some cases.

The final theme, identified as causing moral distress, is called ‘one stop shopping.’ Each of the participants relayed instances of caring for patients in the emergency department who could appropriately be seen and treated at an alternate location. This could occur if they were able to access primary care or were educated regarding appropriate use of the emergency department. Canada’s universal health insurance mitigates financial concerns affecting access to healthcare even though 15% of Canadians reported that they do not have a family physician (Olah, Gaisano, & Hwang, 2013). Some of the participants indicated that the root cause of this distress is a lack of public education regarding appropriate use of and access to health services. However, there is evidence of health care office staff discriminating against people of lower socio-economic status when the financially disadvantaged person attempts to make an appointment at the clinic (Olah, Gaisano, & Hwang, 2013). Thus, despite some patients’ efforts to be seen at an alternate location, many are unable to secure a family physician or gain timely access to their clinic.

Implications

Participants in the study confirmed the existence of morally distressing situations occurring while working in the emergency department. Furthermore, sources of moral distress

were identified by the participants which are similar to those identified in other studies. As has been identified in many previous studies in other acute care areas, one of the sources of moral distress is provision of care that patients are not expected to benefit from, also known as futile care (Elpern, Covert, & Kleinpell, 2005; Lawrence, 2007). Participants described the accompanying frustration that occurs in futile care scenarios and that organizations need to take action to address this reality in their registered nurses. Open communication among all team members is imperative in all patient care situations with honesty and transparency around what can and cannot be done have never been more important than in futile care situations.

Participants also identified triage situations, a shortage of necessary human resources, and a lack of available appropriate treatment spaces as causing moral distress. Timely patient disposition from triage also has implications for emergency department bed management as the results of Knapman and Bonner (2010) suggest that the cumulative effects of time interval delays to an emergency department bed can significantly impact length of patient stay by reducing emergency department capacity.

Fernandez-Parsons, Rodriguez, and Goyal (2013) indicated poor team communication resulted in moral distress for the emergency department registered nurses they studied while in this study, participants spoke of time pressures as affecting their ability to have timely and effective communication, as well as, affecting opportunities for debriefing or mentoring. The implication is that further research in the emergency department is needed specific to the connection between poor team communication and the time pressures faced by registered nurses.

The call for additional support in morally distressing situations from organizations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2000; Elpern, Covert & Kleinpell, 2005; Pauly, Varcoe, Storch, et al., 2009; Shorideh, Ashltorab, & Yaghmaei, 2012).

However, many participants identified the government as responsible for allocation of funds to support additional resources as needed. Further, participants identified the virtual absence of public education related to use of health care resources as contributing to the instances of moral distress they face. The implication is that widespread public education related to appropriate use of healthcare options is needed. In addition, ongoing attention to access challenges from both healthcare providers and consumers will ensure both parties realize the benefits. For patients, they will see more timely access to provision of healthcare services, while the registered nurses will experience less moral distress related to seeing only the most appropriate patients presenting to the emergency department. Thus, decreasing the frequency of patient presentations related to the theme of ‘one stop shopping.’

Chapter 4

Registered Nurses Responses and Reactions to Moral Distress While Working in the Emergency Department

The literature identifies moral distress as a significant problem in nursing. If the number of publications on the topic of moral distress is any indication, awareness of the topic and the overall body of knowledge has increased exponentially in recent years. As defined by the Canadian Nurses Association (CNA, 2008), moral distress is:

Ethical (or moral) distress arises 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 or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress. (p.6)

There is remarkable consistency in the literature related to levels, causes, effects and sources of moral distress. Effects of moral distress recurring in the literature reviewed include: poorer physical and psychological wellbeing, decreased spirituality, decreased self-image, and an increase in medication errors. (Elpern, Covert, & Kleinpell, 2005; Maiden, George & Connally, 2011).

Many healthcare professionals have reported that the emergency department is the most stressful environment in hospitals. Karr (2006) reported that emergency room nurses work in an environment that is volatile and challenging due to frequent exposures to critical incidences and stressful events. Furthermore, high patient volumes and high acuity contribute to this stress and emergency department nurses are highly susceptible to burnout. Stress and burnout are not synonymous. Espeland (2006) indicated that stress itself is a neutral event and that it is up to the

nurse to interpret the stress as being positive (helpful) or negative (unhelpful). She went on to indicate that burnout produces a sense of helplessness or hopelessness while stress can produce energy and urgency. Roach (1994) reported that on the job stress may be the result of role overload. Role overload is a condition Roach defined as, “where the employee experiences too many demands in terms of both time and duties” (p.42). Emergency department nurses are susceptible to role overload which is an element that may lead to burnout. In order to prevent the occurrence of burnout, it is imperative that nurses are cognizant of both the cause and symptoms of burnout (Espeland, 2006).

As was reported in the previous chapter, participants reported that they are experiencing moral distress while working in the emergency department. Sources of the distress include: (a) inability to spend sufficient time with their patients due to competing demands; (b) futile efforts in trauma and end of life care; (c) use of resources and allocation of treatment spaces; and (d) patients use of the emergency department as a primary care clinic. Fernandez-Parsons, Rodriguez and Goyal (2013) reported finding low levels of moral distress in emergency department nurses concluding that these situations, “may be less morally distressing for emergency nurses given the limited knowledge that they have about the patient and/or the patient’s wishes before the event” (p.549).

Research literature has repeatedly demonstrated that Intensive Care and Critical Care Units have nurses who display high levels of moral distress (Corley, Elswick, Gorman, & Clor, 2000; Elpern, Covert, & Kleinpell, 2005; Shorideh, Ashktorab, & Yaghmaei, 2012) yet the most closely related specialty area in all of nursing, the emergency department, is virtually absent from the literature on the topic of moral distress. In fact, only one study directly examining moral distress in emergency department nurses was located. Therefore, the purpose of this

chapter is to understand the way that registered nurses working in emergency departments respond or react to occurrences of moral distress.

Methods

Research design

I used narrative inquiry to explore registered nurses experiences of moral distress while working in emergency departments. The questions focussed on the participants responses to the moral distress. Chase (2005) indicated narrative inquiry is a form of investigation and data collection that retains a narrative-like quality from social life. Narrative inquiry is used to best capture detailed life experiences or stories of a single individual or the lives of a small number of individuals (Reissman, 2008). In narrative inquiry, the researcher requires a clear understanding of the participants' context of their stories. This context includes: participants personal experience; their culture, including their workplace culture; and the historical context of their stories. Narrative inquiry can highlight the researcher as a listener or as a questioner (Reissman, 2008).

Reissman (2008) wrote of researchers utilizing narrative methods on account of the truths that stories reveal. She further indicated that telling stories about challenging times in our lives includes emotions and creates order, which in turn, enables a search for meaning and promotes connection with others. The goal in narrative interviewing is not to generate brief answers or general statements, but to gather detailed accounts (Reissman, 2008). Emergency department nurses share a relatively common context to complete their work, however, their challenges, experiences, truths, and emotions are not necessarily common, making narrative inquiry an appropriate way to study the phenomenon of moral distress.

Sample and setting

I used a non-probability sampling technique. I completed recruitment for the study by e-mailing potential candidates who work in emergency departments throughout the province. Inclusion criteria included working at least 30 hours per week as a registered nurse in the emergency department for a minimum period of at least 2 years. The purpose of including only those working at least 30 hours per week and for a minimum of 2 years was to ensure that all participants had been sufficiently exposed to an emergency department environment to understand the context of that environment. Further, many registered nurses work in an area in a casual or relief status without achieving a high number of hours experience in that area. Hence, the need to have a relatively high number of hours worked per week in the inclusion criteria. Those working in the zone where I am employed were excluded related to my current and previous emergency department positions within that zone. I sent a letter of invitation (Appendix B) to those who responded to the e-mail invitation (Appendix A).

According to Glesne and Peshkin (1992), consideration for having a large number of cases in a study includes ideas for subsequent generalizability which is a term that they claim means little to most qualitative researchers (as cited in Cresswell, 2013). Transferability is a more realistic and achievable goal in qualitative studies. I interviewed twelve participants, the participant demographic form is attached as Appendix E.

Data Collection

The majority of the interviews were completed by video teleconference using Skype with the remainder occurring face-to-face at a location of the participants' choosing. All of the interviews were between one and two hours in length and began with the confirmation of consent. I then provided the CNA definition of moral distress to provide context to the conversation after which the interview began. As advocated by Neuman (2011), I used open-

ended, non-directional questions with additional probing questions throughout the interviews as participants relayed their experiences of moral distress while working in emergency departments. All of the interviews were digitally recorded and I subsequently transcribed each of them verbatim.

Neuman (2011) has written on the advantages and disadvantages of using open questions. Advantages include permitting: creativity, self-expression, richness of detail, and adequate answers to complex issues. Open-ended questions also reveal a respondent's thinking process, logic, and frame of reference. Disadvantages for the participant with this type of questioning include: respondents giving different degrees of detail in answers, which may or may not be relevant or may be buried in useless detail. In addition, an increased amount of respondent time, effort, and thought is required. Disadvantages for the interviewer include: difficulty in coding and comparing responses, and the difficulty of transcribing responses verbatim. The interview guide is attached as Appendix D.

Data Analysis

I used one of the most common approaches, thematic analysis, used by qualitative researchers to analyze the data. Thematic analysis tends to be used with most theoretical frameworks as it is not linked to a particular framework (Braun & Clarke, 2006) and is sometimes called interpretive thematic analysis (Liamputpong, 2009). Reissman (2008) indicated thematic analysis is one of the four general approaches used within narrative analysis. Types of analysis are not mutually exclusive and overlap of techniques can be expected in analysis of qualitative data.

I used inductive production of categories to reveal common experiences among participants. As advocated by Reissman (2008), I looked both within and across interviews to

find themes as provided by the participants. Paying particular attention to the context of the data, I found many of the categories derived are unique to the emergency department environment while others are similar to categories existing in the moral distress literature.

After reading and re-reading the transcripts, I began a process of color coding broad categories and initial coding before I loaded them into NVIVO 10 and used the program to help electronically sort the data, I then printed the categories and began a manual analysis with axial coding. Ultimately, I connected theoretical ideas to the text, interpreted the text and made interconnections between the codes resulting in the ability to make notes on the relationships between the codes, the research questions, and the moral distress literature.

Qualitative research using narrative forms is increasing and trustworthiness must be sought and maintained throughout the study. Trustworthiness is ensuring that the data was ethically and appropriately collected, analyzed and reported (Carlson, 2010). Reissman (2008) cautions that persuasiveness and rhetorical style may convince the reader of the truth within the content but does not necessarily provide the context and will not stand up to academic questioning. Audiences that are academic expect to learn details around how a study was conducted, and about the decision points in the interpretive process that led to particular conclusions and not others (Reissman, 2008). For these reasons, I took field notes at the time of the interviews, as well as, dating and maintaining chronology with subsequent notes and decision points. Narratives collected and interpreted have shifting meanings over time, however, claims for validity can be grounded by precisely documenting the processes used to collect and interpret data (Reissman, 2008).

Ethical Considerations

Respect for persons, concerns for welfare, and justice are the three core principles that provide the basis for the Tri-Council Policy Statement: Ethical Conduct for Research Involving

Humans (2010). I have attended to each of these principles throughout the process and ethical approval for the study was obtained from a University Human Subjects Research Committee prior to commencing any data collection.

In an effort to conduct ethically sound studies, researchers must find a means to contain awareness of the possible harm rather than to silence it (Josselson, 1996). Josselson identified potential harm we may do to ourselves and participants in narrative inquiry. Participants may reveal more in the heat of the moment than they committed to when consenting to take part in the study. This possibility is identified as more likely in the method of ethnography when the interactions between the researcher and participant have developed over time, however, it does remain a possibility in narrative inquiry.

I had the participants select a pseudonym, or assigned them one, at the time of the interview. As identified by Clandinin and Connelly (2000), guaranteeing anonymity in a meaningful way is challenging in qualitative research. I modified or removed identifying information in the transcripts in an effort to protect the identity of the participants. In some cases, I modified some information regarding patients or work environments as described by the participants to remove identifiers without losing context or meaning.

I obtained consent prior to commencing the interviews. For the face to face interviews, I presented the letter of consent prior to the interview, I asked the participant to read it over and answered any questions that they had related to the consent. I then verified that they understood the information, and finally, obtained their signature prior to the interview. When using Skype for the interview, I sent an electronic consent form to the participant prior to the interview. The same process was completed with these participants, that is, having the participant read the consent form, answering their questions, verifying complete understanding to what they are

consenting, and ultimately, receiving digitally recorded verbal consent prior to the interview. No participants withdrew consent at any time. All participants were sent a \$10.00 gift card in appreciation of their time and effort.

Results

Regarding the registered nurses reactions to moral distress in emergency departments (ED), there were three major themes evident at the time of data analysis. The first theme, “It’s not going to change anything,” details the participants perceived lack of power, the system they work in, and the sense that there is nothing that they can do about moral distress and in turn, why bother thinking about it. The second theme, titled, “I love my job,” is about the passion emergency department nurses have for their position and the personality type of the emergency department nurse. The third theme, “Deal with it,” details participants’ methods of dealing with moral distress.

It's Not Going to Change Anything

In addition to nurses indicating that there is insufficient time to think about moral distress, there were a considerable number of comments from participants that indicated that they feel powerless to address these situations. For many of the participants, the reason was related to having many competing demands, while others expressed some fear of voicing their thoughts or concluding that it would not change anything. Some of them are resigned to the fact that morally distressing situations come with the territory and that is “just the way it is.” As an example, Christy commented that each emergency department has to develop solutions to meet the government mandated performance targets on their own, saying:

It's just, "here's the target, you figure it out." Even when we laid out a very good case for why we need extra staff, they said, sure you can have extra staff, what are you going to give up? We really do not have the services to give up, we are a service and we don't have the resources to give up. [Health Region] executive is in a bit of a tight spot. The government is micromanaging them a little bit, there are saying you will do this but they are not giving them any extra money, so they have this pull.

Many participants spoke of remaining busy providing patient care from the start to the finish of every shift which left no time to address concerns. Some of these individuals did indicate that their managers, educators or administration "are doing all they can" to provide support and address the apparent resource shortfalls causing moral distress. Jessica indicated managers are doing all that they can but nurses "are at the brunt end of it all." Despite their considerable experience, several participants had difficulty differentiating whether volume or acuity is a greater contributor to the busyness in emergency departments, indicating it is a combination of both. Sue described her department as follows:

It went up from about 190 to 240 max [number of daily visits] and I don't know for sure but it seems like the acuity is getting higher. Most of the numbers that are coming in, I think, are the lower acuity more annoying things. It is more of the patient load and the staffing issues and feeling like you are running short.

Sue was not alone in describing higher acuity and higher patient volumes as contributing to feeling overwhelmed and feeling as though they do not have sufficient staffing resources. Elaborating on this thought, Ben said "the almighty dollar" dictates resources and that being

“expected to do more with less” is a daily occurrence in his area of work. Ann commented along the same lines with resignation in her voice:

I think the system really works against us in some ways, because it's so financially driven, or protocol driven, that you can't really think outside the box. And sometimes I want to think outside the box to fix the system errors and I think we need to do more of that and be more active that way in order to make change.

In some cases, so pervasive is the sense of powerlessness to make change or challenge situations that cause moral distress, that some of the participants indicated it is simply not worth it for whatever reason. Phil provided a few examples of this including commenting on a Personal Care Aid (PCA) who, on a daily basis, refuses to do the parts of her job that she does not feel like doing, a charge nurse he describes as a bully and physicians' not worth approaching for order changes due to their personalities. He said there is not a lot of momentum from nursing staff to address these situations. He added:

At the end of the day I am not going to get into fisticuffs with somebody, if they want to do something, okay, the relationship is not worth it, it's not going to change anything...I think confidence is the main thing patients' need [to see] and when they see that you are a little uncertain in what you are doing, they ask more questions and it takes more time. The more time you spend butting heads with people, the more time it takes and the worse it is for patients.

Several participants relayed stories of frustrating and challenging interpersonal circumstances that fester but which they chose not to address directly. Alternatively, some of the participants addressed negative interpersonal relationships, or outright bullying, from their

colleagues and chose to intervene. Examples include one participant who witnessed others getting bullied by her nursing colleagues and intervened only when she was subject to the same treatment herself. Another participant, Edna, initially found that when she addressed bullying in her area with management that it was the victims whose assignments were initially changed to less acute areas, rather than the bullies being disciplined and removed from these areas. Another participant indicated it was not until there was a managerial change that she saw any meaningful change in the way these situations were handled. Wendy expressed concern around the physical and psychological effects moral distress may have on nurses over time stating:

Some people say, “it happened, let’s move on to get past it.” Others cannot do that. I can’t believe there isn’t someone that hasn’t had their health affected by this. I can’t imagine that someone cannot go through their whole career, things do happen like this and I can’t believe that it has not made someone ill through it.

Sue described being verbally assaulted “at least” daily and how there is no recourse for the nurses. She indicated that she has never been physically assaulted but stated that many of her colleagues have. On powerlessness, Sue said:

If we have patients who are restrained and frustrated and intoxicated, then it’s not their fault that they kick us, swear at us, spit at us. I do not know one nurse in our department who has successfully prosecuted a patient.

One of the participants indicated that she had left work in an emergency department partly due to moral distress, however, she did continue to work in another emergency department. In her case she “went systematically up the ladder” addressing her concerns with the charge nurse, the manager, the physician involved, and the head of the physician group

without a satisfactory result. Two other participants indicated there was a mass exodus of nurses from their emergency department following a major event where they were not supported by the CEO and “knew that they would be blamed” for any [negative] outcome the patient might suffer. Both indicated that the nurses know what they need to do, know what they want to do, and simply cannot.

Burnout was mentioned by several participants with mixed responses on whether the burnt out nurses remained working in their emergency department. Chloe directly attributed burnout to moral distress observing:

I think in nursing, there are times, you can be an amazing nurse for thirty days in a row and then on the thirty-first day do one crappy thing and then hear about it for the next thirty days, right? All those times stick out in your mind way more than the amazing time you had with a palliative patient or whatever. So all those times stick out in your mind and they do cause frustration and there's lots of burnout that happens because of those morally distressing situations.

I Love My Job

Although many participants described hopelessness around some aspects of their work, they still highlighted the love that they have for their jobs. Moreover, it seemed to be their personalities that enables them to persevere and thrive in the emergency department environment. Whether or not the participant was a self-described “adrenaline junkie” or “type A,” personality it seems to be a protective factor for the participants. Several participants explicitly stated that they love their job in the emergency department while others stated this more subtly as they described the passion that they have for their work. Some indicated it’s an addictive area, while others expressed that they have a lot to offer to those in their greatest time

of need and that they cannot imagine working anywhere else. Christy qualified her passion for the emergency department saying, “I love my job, I truly do, but it’s the staff that you work with. It’s the people, not the work.” Ben was succinct in his description of how he feels about his job in the emergency department saying, “I love my job, I do. I think everyone in our department, as much as we all bitch, moan, and complain about things, we wouldn’t do it if we didn’t want to do these things.”

The personalities of the participants shone through in the interviews. There were many statements made across several interviews that were indicative of the participants sharing personality traits and a common approach to their work. Some examples of these traits included that the participants demonstrated independence, confidence and the fortitude to do the right thing in difficult situations. Commenting on the importance of effective communication in emergency departments, Phil attributed the open dialogue to the “type of personalities” that gravitate toward working in the emergency department. When the nurses spoke of their busyness and the considerable demands and stress placed on them daily, they reported it with a high degree of satisfaction. Many of the comments suggested that they had a lot of pride in working in the emergency department which they reported to be not only very challenging but rewarding. Sue summarized this notion:

We sometimes refer to each other as the family or the team. It definitely helps how long you have been there, for how long and for how comfortable you are in the group. We joke about others who work in elsewhere and then come back...our personality types contribute too, it is almost like those who can't handle it get weeded out. I don't want to say "A" type because we are not all like that, but we are definitely more aggressive and confident in general I think.

Aliza, who missed almost a year of work when she had her hand fractured by a brain injured patient who kicked it as she attempted to help her, spoke of her job:

You asked these questions that made me think of where I'm growing and give me more perspective. I love working as an emerg (emergency) nurse, I grew up in a small town and the things you encounter, I would never have known. The gunshots and the drugs have really opened my eyes, it's been a great learning experience.

Deal With It

This theme includes nurses coping mechanisms, the effect of their confidence and assertiveness, and their ability to negotiate and interact with other healthcare team members who may have more perceived power. The participants mentioned many different means of keeping the level of moral distress they experience in check. Some indicated work/life balance is a key factor, while others spoke of exercise, counselling, communication, and relationships factoring into management of the inevitable moral distress they face at work.

Repeatedly, participants expressed their strong desire to simply provide good patient care. They reconcile a perceived shortage of resources and intermittent inability to provide the level of care they feel that their patients deserve by turning to the team for help. Participants commonly used the terms team and family to describe their co-workers. Ben explained turning to his colleagues for support:

I think that we've got a good team and I'm sure there's other places that don't have what we have but you know we lean on each other, support each other, and that's the most important thing because we don't get it elsewhere, so that is where we have to turn.

Commenting on the hierarchical system in health care, participants indicated likeminded individuals are drawn to work in the emergency department resulting in the team atmosphere previously described. Another benefit for the staff is the ability to safely question or comment on patient care generally without fear of negative repercussions. Aliza pointed out that the exception to this is with those who are “always obstinate.” As Christy described:

There will always be that power imbalance between the physicians and the nurses but for our staff I would say between the physicians and the nurses, they are always on a level. We have had one or two physicians come through who are different but they learn. We almost always work together as a team. Everyone has a role and they work in it.

According to the participants, the working relationships among team members with different responsibilities are more collegial in the emergency department than in other areas of nursing. Wendy noted that it is part of the registered nurses professional responsibility to speak up for their patients when they are unable to do so. She added that initiating conversation enables learning of what others “decision process is” resulting in a better learning and working environment. This ultimately translates into increased respect among team members and “can only help the team dynamic.” Wendy concluded:

So, for me it’s working with them and getting to know them and them getting to know me. I know some of them have gotten to know me and will trust me with my work. I think that working relationship is so important and it comes down to decisions.

Autonomy is another factor that participants claimed helped them to mitigate the effects of moral distress. Many of the participants indicated that the treatment protocols used in the emergency department are not used in other departments which gives the users a sense of

autonomy. Some went on to say that getting a verbal order for a treatment outside of a protocol is not uncommon. Phil described that scenario, “my knowledge is definitely a factor in if I ask and also how I am feeling in my day.” Several participants indicated that their input and opinion were sought in cardiac arrests, traumas, and many other critical and non-critical situations. Some individuals said that a mutual respect and level of emergency experience contribute to the degree of input that they have in those situations. Chloe summarized:

This happens a lot more in emergency because typically the relationship between physicians in emergency and nurses is a lot closer than it is in other areas. I believe that the physicians trust the staff a lot more than they do in other areas. So often this happens near the end of a shift, and the doctors are tired, and you call for an analgesia order and the doctor says, “Yea, give them whatever you want.”

Two of the participants disclosed that they had sought counselling outside of the work environment, at least in part, due to the moral distress that they experience at work. In both cases they indicated it was effective for gaining strategies to keep the situation under control. Others spoke of socialization with co-workers as effective for limiting the negative effects that moral distress can have over time.

Several participants described work/life balance as important in mitigating the negative effects of moral distress. Three of the participants indicated that their spouses act as a barometer for when they need to be more physically active in their time away from work. Aliza says exercise and rest are both important for her:

Well again, it’s stress, I’ll be bothered but I found that exercise has helped me kind of deal with it. If I’m having a really rough day I’ll just go swim for an hour and then I’ll

have a different perspective. I found that exercise is a venue to deal with the stressors, sleep is always a factor too.

Beyond actively taking steps to address their inability to do the right thing in the workplace, some participants indicated maintaining a sense of humor is important while others found a more introspective approach can be effective. Sue spoke of how “it affects everyone differently” and added, that they joke about being called explicit names by patients at triage three minutes into their shift. Jessica suggested personality dictates the level of comfort nurses have in addressing issues. She summarized on the importance of self-reflection:

I think it’s important to have situations where you feel distressed because it forces you to look inwards. It’s important to do that reflection. I think sometimes without that stressor we go day to day without thinking about what we’re doing.

DISCUSSION

Limitations

There are limitations that must be recognized in this study. First of all, while the relatively small sample size of 12 is appropriate in a qualitative study of this nature (Cresswell, 2013), I completed my research related to a highly specialized area which means that the findings cannot be generalized beyond the participants’ work settings. In addition, two of the twelve participants work in rural emergency departments which is a small representation of that demographic as there are dozens of rural sites within the province. Had there been a higher amount of participant representation from rural sites, the results may have been different. Similarly, had the data been analyzed by another researcher, the findings may not have been the same. Secondly, despite my efforts to ensure that the data was objectively analyzed, my experiences working in the emergency department negated the possibility of completely

objective analysis. In addition, my work and life experiences influence the themes that emerged and another researcher may have produced different themes based on the data. Thirdly, participants self-selected and some potential participants may have elected not to participate related to the sensitive nature of the topic or related to the perceived powerlessness to make changes related to the moral distress that they are experiencing in the emergency department.

General discussion

This study is possibly the first to qualitatively examine the reactions registered nurses have to moral distress while working in an emergency department. Zuzelo (2007) reported moral distress has been found to be manifested as frustration, anger, guilt loss of self-worth, anger resentment, sorrow, anxiety, helplessness, depression, nightmares, helplessness, and hopelessness. The first theme of ‘it’s not going to change anything’ focused on the perceived lack of power that the registered nurses have to change anything related to morally distressing situations and the sense that there is nothing they can do about it. Participants spoke of the finite amount of human resources that they have and how redistribution of these resources within the department will not create an ability to do the right thing. The ability to do more with less as patient volumes increase is a pervasive situation described by the participants. The effect or result of moral distress contributes negatively to job satisfaction, retention, physical and psychological well-being, and self-esteem (Elpern, Covert, & Kleinpell, 2005; Maiden, 2008). I found participants reported retention concerns as several had mentioned registered nurses leaving the emergency department due to moral distress. Fewer participants reported the negative physical and psychological impacts described above.

This lead to the second theme of ‘I love my job’ which is about the passion emergency department registered nurses have for their positions despite a perceived inability to decrease the

instances of moral distress in their work environments. Ranging from self-described ‘adrenaline junkies’ to type A personalities, there were common personality traits noted among the participants that seem to help them thrive and persevere in the emergency department environment. Combining this knowledge with the unanimous declaration of love for their jobs, I have to surmise that the participants’ personalities contribute to mitigation of moral distress in their work environments.

The final theme called ‘deal with it’ detailed the participants coping mechanisms, the effect of their confidence and assertiveness, and their ability to manage interactions with those ascribed a higher level of authority in healthcare hierarchies. Some of the participants spoke of the high degree of collegiality between physicians and nurses in the emergency department which clearly mitigates the degree of moral distress experienced by emergency department nurses. The participants indicated institutional policy, disrespectful communication, and power imbalances that compromise their integrity which is consistent with the findings of Fry, Veatch and Taylor (2011), however, the reactions and outcomes of these instances resulted in participants developing tools to manage the situations rather than leaving their jobs. Some participants turn to counselling while others engage in more active lifestyles away from work, and still others find socializing and interacting with colleagues informally helps them to debrief.

Implications

The consistency in reactions to moral distress among participants is remarkable and informative to those working in emergency departments and for decision makers. The sense of inability to change the situations causing moral distress is so pervasive it cannot be ignored. While just one participant in the study left an emergency department related to moral distress, she remains employed at another emergency department. There are several other participants

who described knowing registered nurses who stopped working in emergency departments due to moral distress.

Of all the types of aggression that nurses encounter (patient-to-nurse, nurse-to-visitor, physician-to-nurse, and nurse-to-nurse), nurses reported that nurse-to-nurse aggression is the most distressing type (Johnston, Phantharath, & Jackson, 2009). Nurse managers are most often seen as the principal perpetrators of bullying within the profession (Johnston, Phantharath, & Jackson, 2009) and bullying arises from organizational cultures that tolerate violence in the workplace (Speedy, 2006). The implication is that when management and peers do not set limits on bullying behavior, the organizational climate changes and, over time, subconsciously supports the behavior (Johnston, Phantharath, & Jackson, 2009). Front line clinicians, managers, and other decision makers must not delay in engaging their teams in finding solutions to decrease the frustration experienced by registered nurses related to instances of moral distress. The call for additional support from organizations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2000; Elpern, Covert & Kleinpell, 2005; Pauly, Varcoe, Storch, et al., 2009; and Shorideh, Ashltorab, & Yaghmaei, 2012).

Participants consistently reported passion for their work despite encountering morally distressing situations. They indicated that there are common personality traits, or types of people, who gravitate towards working in the emergency department. Therefore, it is imperative that the registered nurses hired into emergency departments are suitable to the environment. Valuable examples of personality traits described by the participants include: confidence, independence, helpfulness, and fearlessness. Two opportunities for hiring managers to ensure their candidates meet these criteria include at the time of interviews and at the time of checking references.

Fernandez-Parsons, Rodriguez, and Goyal (2013) indicated the brevity of patient encounters with registered nurses contributed to the resulting low level of moral distress in emergency departments compared to the moderate and high levels reported in other areas. Similarly, participants in this study indicated the need to move quickly from one patient to the next potentially mitigates the negative effects of the accompanying moral distress. The implication moving forward is a need to conduct research related to the cumulative effects of frequent, if not constant, low intensity instances of moral distress in emergency department settings.

Several participants indicated the dynamics that occur between health region executive leadership and the provincial government directly contributes to the instances of moral distress experienced by emergency department registered nurses. The participants suggested the “targets” for provision of care in the province were not necessarily combined with accompanying resources necessary to achieve the goals set for them. The implication is a need for more momentum from healthcare providers and the general public to ensure policies reflect provision of sufficient resources to safely and effectively manage increasing patient volumes and acuity presenting to emergency departments.

The participants identified various ways of dealing with moral distress prior to it resulting in physical or mental illness. As identified by the participants, the implications for those working in emergency departments is a need for effective respectful communication at all times, making time for debriefing a necessity, and achieving and maintaining work/life balance. In several instances, participants cited physical activity as effective for mitigating the negative results of moral distress. Another implication for emergency department staff is to be inclusive of all staff members when organizing group physical activities outside of work. The benefits of

participating in these team building exercises will include both combating moral distress and improved physical health. All team members, including physicians, nursing administrators and leaders, must be motivated to acknowledge and discuss the phenomenon to improve both the culture and climate of their emergency departments.

Chapter 5

Discussion and Recommendations

Discussion of Findings

The literature identifies moral distress as a significant problem in nursing. There is a remarkable consistency in the literature related to levels, causes, effects and sources of moral distress. The most frequently noted causes of moral distress indicated in the articles reviewed are providing futile treatment, prolonging the dying process, a perceived shortage of resources or working short staffed, and the hierarchical nature of nurse/physician relationships. In some instances this is demonstrated as extending to nurse to nurse or nurse to patient/family relationships dependent upon the context. Effects of moral distress recurring in the literature reviewed include: poorer physical and psychological wellbeing, decreased spirituality, decreased self-image, and an increase in medication errors.

Research utilizing instruments developed by Corley, Elswick, Gorman, et al. (2001) and Corley, Minick, Elswick, et al., (2005) are most commonly used for quantitative components of research while interviews and questionnaires specific to acute care areas, more frequently in ICU settings, are most common in qualitative circles. The greatest number of studies found on moral distress include critical care (or ICU) nurses as participants with moderate levels of the phenomena found at all sites studied and the highest levels of moral distress occurring in situations where care is provided to those not expected to benefit from the treatment.

Many of the participants identified time pressures as causing morally distressing situations. They identified knowing that often the right thing to do was to spend more time with the patient in front of them. However, due to competing demands and the influx of new patients,

there is a need to move on to the next patient sooner than they would if they were given the opportunity to stay with the patient for which they were currently caring. Participants repeatedly indicated time constraints were woven throughout all of the themes causing moral distress. The other themes identified in chapter 3 include: futile care, being caught between a rock and a hard place when making decisions, and one stop shopping, where participants expressed the need for public education around appropriate use of the emergency department.

Similar to previous research on the phenomenon, futile care, or providing care the patient is not expected to benefit from, was identified by participants as causing moral distress (Elpern, Covert, & Kleinpell, 2005; Fernandez-Parsons, Rodriguez, & Goyal, 2013; Shorideh, Ashktorab, Yaghmaei, 2012). In 2005, Corley described the benefits of understanding the power relations that occur between nurses and physicians. These relational imbalances were recognized by participants as contributing to moral distress in emergency departments with several participants indicating that the relationships between the two groups influence the nurses' discomfort in addressing these situations. Similarly, Jonsson and Halabi (2006) found that dealing with doctors caused the most stress in emergency department nurses. Other factors identified by the participants as helpful in forging relationships between physicians and nurses include the length of time both parties have worked in the department and the personalities of both the nurse and physician involved in the interaction.

The other themes identified by emergency nurses as causing moral distress, were not identified in previous research reviewed. The themes of triage decisions and inappropriate accessing of the emergency department do not appear in the existing literature. This is partly due to other areas not utilizing formal triage systems and can also be attributed to staff in other areas having the ability to divert their patients to an emergency department. Contrarily, emergency

department staff are expected to see and treat all patients who enter to their area without an ability to divert patients.

Chapter 4 includes registered nurses' reactions and responses to moral distress in emergency departments. Elpern, Covert, and Kleinpell (2005) list moral distress as contributing negatively to job satisfaction, retention, physical and psychological well-being, spirituality and self-image. Maiden, Georges, and Connelly (2011) acknowledge this research and go one step further by including medication errors as resulting from moral distress.

Three themes were identified through inductive analysis of the data. The first, "It's not going to change anything" recounts the findings of participants who indicated that burnout in emergency department nurses is related to the unique stressors that they face and that there is no use addressing it. Reasons for this include feelings of powerlessness, a lack of support from those in authority to make changes, and a general sense that it will not change anything. For example, several participants indicated that they had previously addressed their concerns with no notable changes made to improve or mitigate the circumstances. As a result, they are resigned to accepting the situation is the way it is and will remain so.

The notion of nurses accepting the status quo is not new to nursing. In fact, many researchers have written on the related topic of oppression in nursing with several indicating there has been an assumption in nursing circles that horizontal violence occurs because they are oppressed (Cox, 1991; Roberts, 1983; Simons, 2008). In Freire's (2003) theory of oppression, he contends that situations of oppression can be changed because it is the result of an imbalanced social structure, not fate. Freire further theorized that oppressed people internalize their situation by adopting the dominant group's beliefs and values while minimizing their own. Bartholomew (2006) postulated that the idea that nursing is an oppressed discipline has its origins in gender

issues and that it is substantiated by significant literature. This is because medicine is male physician dominated while nursing is female dominated and, “who else to be oppressed by the predominantly male physicians but the predominantly female nurses?” (Johnston, Phantharath, & Jackson, 2009, p.39). It seems only natural that with increased pressures, stresses, and expectations within the nursing profession, hostility will arise and, unfortunately, we tend to take it out on each other (Johnston, Phantharath, & Jackson, 2009). Fortunately for patients, healthcare staff, and physicians, the registered nurses who tend to gravitate towards working the emergency department possess traits that benefit patients and staff as evidenced in the following themes.

The second theme titled, “I love my job” reveals participants passion for their positions within emergency departments. Participants expressed their desire to continue working in the emergency department despite circumstances of overcrowding, increasing patient acuity, and situations they identified as causing moral distress. Many participants described emergency department nurses as sharing personality traits which provided protection for them against the negative effects of moral distress.

The third theme titled, “deal with it” details participants means for handling the effects of moral distress. Notably, the relationships between team members in the emergency department are described by participants as closer than in other areas of nursing which results in more comfort in communicating their concerns. However, the opportunity to address issues in real time are limited by competing time constraints. Participants indicated self-care through proper rest and exercise are helpful in dealing with the effects of moral distress. The most common response to moral distress that participants utilize is to seek counsel from a friend, spouse, or formal counselling.

Implications for Nursing Practice

Identifying moral distress as an inevitable reality in healthcare, does not negate or change practice standards, regardless of the cause of the distress. For example, participants in the study identified time pressures and a lack of time to spend with patients and their families as causing moral distress, this knowledge does not alter documentation standards or assessment expectations. The implication for nursing in the emergency department is a need to identify causes of the distress and address these situations to ensure that other areas of their care are not negatively impacted. Fortunately, participants identified themselves as generally confident and adaptable, which well lends itself to both succeeding in the emergency department and to effectively managing situations of moral distress. Although there was no data connecting the experience of moral distress directly to patient care, a connection can be inferred as there is a possibility that individuals do not know that they are experiencing moral distress as they do not fully understand the concept (Austin, Lenermeyer, Golman, Bergum, & Johnson, 2005). Regardless of the cause of moral distress, frontline nurses must learn to identify the phenomenon and know what resources are available to them to address these situations in real time once they understand the concept.

Fernandez-Parsons, Rodriguez, and Goyal (2013) indicated the brevity of patient encounters with registered nurses contributed to the resulting low level of moral distress in emergency departments compared to the moderate and high levels reported in other areas. Similarly, participants in this study indicated the need to move quickly from one patient to the next potentially mitigates the negative effects of the accompanying moral distress. The implication moving forward is a need to conduct research related to the cumulative effects of frequent, if not constant, low intensity instances of moral distress in emergency department

settings. Another implication is the need for further research in the emergency department specific to the connection between the identified causes of moral distress and the time pressures registered nurses are facing in that environment.

Knowing there will be some degree of moral distress experienced by registered nurses, nursing schools must incorporate education in this regard into their curriculums. More specifically, nursing educators need to provide students with known causes and effects of moral distress, as well as, the related topics of burnout and oppression in nurses. This knowledge can be used by the students increase their awareness and to afford them the ability to plan their reactions, and ideally generate some pre-emptive dialogue on the topic, prior to being caught in the middle of these difficult situations in the workplace. Further, by providing tools to mitigate moral distress at the time of nursing education, new nursing graduates will not only be better armed to manage the inevitable morally distressing situations they find themselves in but able to model characteristics of collegiality in their interactions with staff from all disciplines.

The provincial regulatory body for registered nurses mandate is to protect Albertans by ensuring that they receive safe, effective, and ethical care by registered nurses (CARNA, 2014). Challenges introduced by morally distressing situations increases the difficulty nurses have in fulfilling this need. The frontline nurses require support from their managers, directors and higher levels of administration to ensure that there are sufficient resources supporting them. Further, participants identified the virtual absence of public education related to use of health care resources as contributing to the instances of moral distress they face. The implication is that widespread, ongoing public education related to appropriate use of healthcare options is needed.

Recommendations calling for support to combat moral distress by senior administration and managers are made throughout the literature (Corley, Elswick, et al., 2001; Elpern, Covert,

& Kleinpell, 2005; Pauly, Varcoe, & Storch, 2009; Shoride, Ashktorab, & Yaghmaei, 2012; Wilkinson, 1987). Several participants indicated the dynamics that occur between health region executive leadership and the government directly contributes to the instances of moral distress experienced by emergency department registered nurses. The participants suggested the “targets” for provision of care in the province were not necessarily combined with accompanying resources necessary to achieve the goals set for them. The implication is a need for more momentum from healthcare providers and the general public to ensure policies reflect provision of sufficient resources to safely and effectively manage increasing patient volumes and acuity presenting to emergency departments which, in turn, will decrease the instances of moral distress experienced by registered nurses. Frontline nurses, nurse administrators and leaders have a responsibility to acknowledge the phenomenon and take action to improve both the culture and climate of their departments.

Limitations

There are several limitations to my study. For example, the findings are not generalizable which is common in qualitative studies as they have very different purposes and strengths than being generalizable (Cresswell, 2013). Rural emergency department registered nurses represented just two of the twelve participants which means the results are potentially less representative of rural sites. In addition, some potential participants may have opted not to participate due to the perceived normalcy of moral distress in their work environment or their perceived powerlessness to change the status quo. Others may have elected not to participate due to the potentially sensitive nature of the topic and concern for the emotion and impact the interview might have.

Recommendations

Based on the limitations noted for this study, one recommendation is to complete further research with emergency department registered nurses and with more rural emergency departments represented. Another recommendation is to be inclusive of participants who have left a position in an emergency department related to moral distress as their experiences may reveal additional causes of moral distress not yet found in the literature. Overall, more research and education on the phenomenon are required. From an educational perspective, teaching nursing students about the topic should start in year one of their schooling as one of the few certainties on the topic is that all healthcare providers will be exposed to it to some degree. From a research perspective, additional emergency department studies on the phenomenon are recommended in all departments employing registered nurses.

Conclusion

This qualitative research study examined emergency department registered nurses experiences of moral distress. Chapters 1 and 5 served as introduction and conclusion respectively for the study. In chapter 2, I examined literature related to moral distress in all areas of nursing with additional information related to stress and burnout specific to emergency department nurses. Chapter 3 detailed causes of moral distress as identified by the participants. Chapter 4 included participants' reactions to the moral distress they experience while working in the emergency department.

This study revealed the experiences of moral distress registered nurses have while working in emergency departments in the province of Alberta. Increasing patient acuity and patient volumes are adding to the time pressures causing morally distressing situations which, in

turn, is resulting in increased stress and feelings of burnout in these nurses. Fortunately, the personalities of many emergency department nurses are such that they are protected from significant harm from the ongoing instances of moral distress. In moving forward, it is imperative that registered nurses arm themselves with the knowledge to recognize moral distress and communicate the need for support to address instances of the phenomenon with their leaders and management. Similarly, organizations must communicate with frontline nurses who know what is putting them in situations where they are unable to do the right thing. Then, leaders must be clear regarding their expectations of all staff and physicians to ensure all employees have the ability to address situations in a timely manner and in a safe environment.

Dissemination of Research

This thesis contains one method of dissemination. I intend to engage in other methods of dissemination activities which include: (a) presentation at emergency departments conferences; (b) provision of an executive summary (Flynn & Quinn, 2010) of research results to all study participants; (c) submission of chapters 3 and 4 as separate papers to scholarly journals for publication, and (d) presentation at practitioner workshops which has also been advocated by Flynn & Quinn (2010). The findings of my study do not reflect all statements made by the participants and this may be upsetting for some of them. Similarly, some frontline nurses may view the results as differing from their experiences of moral distress in the emergency department. It is my intention that the findings of the study best reflect the data collected in order to generate conversation about the topic. Thus prompting staff at all levels to consider, implement measures to manage, and decrease instances of the moral distress in emergency departments.

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Appendix A

Recruitment Flyer for Emergency Department Moral Distress study

EMERGENCY DEPARTMENT: REGISTERED NURSES

Moral Distress in Emergency Department Settings: Registered Nurses Experiences



The Canadian Nurses Association (CNA, 2008) define ethical (or moral) distress 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 or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress.

Participants are being asked to participate in an audio-recorded 90-120 minute interview at the time and date of their choosing.

All participation is completely confidential and voluntary. Participants will receive a \$10.00 Tim Horton's gift certificate in appreciation for their participation.

If you are a Registered Nurse currently working in the Emergency Department outside of the Southwest Zone, please contact Kevin Reedyk at: 403 394-3646, or e-mail: k.reedyk@uleth.ca

Appendix B

Letter of invitation to potential participants in study of registered nurses experiences of moral distress in emergency departments.

Date: 2013

Dear prospective research participant,

My name is Kevin Reedyk and I would like to thank-you for responding to my invitation to participate in my research study. I am a Registered Nurse currently enrolled in graduate studies at the University of Lethbridge and working towards my Master of Science degree in Nursing. I am conducting research as part of the requirements for this degree, and I would again like to invite you to participate in my study.

I am conducting a narrative inquiry examining registered nurses experiences of moral distress while working in emergency departments. As a participant in this study you will be asked about situations you have been involved in while working in the emergency department where you knew the right thing to do but were unable to do so for some reason. The interview would be approximately 90 minutes to two hours in length and you will have an opportunity to review the information you have provided prior to any submission of the information to another source. The interview will be audio-recorded and will take place at a time and location that is convenient for you. Your anonymity and confidentiality will be maintained throughout the process. As a Registered Nurse, I am not only bound to confidentiality as a researcher but also as a Registered Nurse.

As a token of appreciation for your participation, you will receive a \$10.00 gift card. If you withdraw prior to conclusion of the study, you will still receive the gift card. Further, reimbursement will be provided for gas expenses and parking as applicable.

Thank-you in advance for consideration of my request. If you remain interested in this research study, please contact me at the confidential e-mail address below to discuss your participation and schedule for the interview process. If you have any questions or require additional information, please call or contact me at k.reedyk@uleth.ca or (403) 394-3646, or contact my supervisor, Dr. Brad Hagen at brad.hagen@uleth.ca or (403) 329-2299.

Sincerely,

Kevin Reedyk, RN BN
MSc student, Faculty of Health Sciences
University of Lethbridge
Cell: 403 394-3646
Confidential e-mail: k.reedyk@uleth.ca

Appendix C

Registered Nurse Participant Consent Form

Study title: Moral Distress in Emergency Department Settings: Registered Nurses Experiences

Date: 2014

Dear Registered Nurse,

You are being asked to participate in a study about the experiences of moral distress in registered nurses working in emergency departments. More specifically, you will be asked about your experiences of knowing the right thing to do while working in the emergency department but being unable to do so for whatever reason. The purposes of the study are to: A) determine if registered nurses are experiencing moral distress while working in the emergency department, B) if so, understand the experiences of moral distress registered nurses have while working in the emergency department, C) understand what contributes to the experiences of moral distress.

Your involvement includes one 90 to 120 minute audio-recorded interview at a time and location of your choosing with a subsequent opportunity for you to review a manual transcription of the interview to confirm accuracy of the content and meaning. Further, if there is any need to clarify or expand on any of your previous statements, this will be the time to do so. It is anticipated that follow-up clarification will not exceed an additional 20 minutes of your time and may be completed over the telephone if that is what you prefer.

There are no known physical risks to participating in the research, however, there may be emotionally uncomfortable situations that arise from recalling negative experiences. In the unlikely event this does occur, simply let me know and I will turn the recorder off until you indicate that you wish to continue with the interview or indicate you wish to withdraw your consent and discontinue your participation in the study. If you feel you wish to continue to discuss your feelings and experience with a professional counselor, I will provide contact information for support that is available to you in this regard.

While you will not benefit directly from this research, potential benefits include the possibility of your colleagues, management and administration seeing the results of the research and incorporating the recommendations into their emergency departments. Again, all results will have identifying information removed and you will not be able to be identified as a participant in the study.

You will be asked to complete a demographic information form including topics such as; gender, age, number of years of nursing experience, and selection of pseudonym to be used as an identifier throughout the study. Use of a pseudonym will ensure your anonymity is maintained and demographic information, such as gender and years of nursing experience, will be removed from the results. Prior to any publication, only my supervisor and I will have access to the data collected. If a transcriptionist is used following the interview, they will only have access to your data with the pseudonym attached. Any transcriptionist used will also sign a confidentiality agreement. Your name and demographics will not be shared with others. All transcripts and

demographic information will be stored in a locked drawer in my office for seven years at which time it will be shredded and destroyed as confidential waste. Any electronic record of your demographic information will be stored on a password-protected computer with restricted access until your data has been transcribed and verified by you, at which time it will be destroyed.

As a token of appreciation for your time and contributions, each participant will receive a \$10.00 gift card. Another benefit of your involvement in the study is the knowledge that you are may be aiding your colleagues to manage situations of moral distress.

With your permission, the interview will be digitally recorded, and transcribed by the interviewer exactly as spoken. The location of the interview will be mutually agreed upon and will not be conducted at an Alberta Health Services site. Your participation in the study is voluntary and you may withdraw at any time without consequence. If you withdraw, any information previously collected from you will be destroyed. Failure to participate will not result in any penalty, prejudice, or impact your employment in any way.

The study findings will be shared by way of presentations and publications in nursing journals in a manner that maintains your privacy and confidentiality. The purposes of sharing the findings are to: 1) enable other emergency department employees to learn and gain tools to manage similar situations, 2) to potentially educate registered nurses regarding the existence of moral distress and enable both to mitigate the instances of same.

As a participant in the research, if you choose to receive the results, you will be informed by way of e-mail or posted mail, whichever method is most convenient for you.

The research is being conducted by Kevin Reedyk RN, BN as part of the Masters of Health Sciences program, Faculty of Health Sciences, University of Lethbridge. For additional information regarding the study, please contact the Principal Investigator, Kevin Reedyk, at k.reedyk@uleth.ca or (403) 394-3646, or Dr. Brad Hagen (Supervisor) at brad.hagen@uleth.ca or (403) 329-2299.

Any questions regarding your rights as a participant in this research may be addressed to the Office of Research services, University of Lethbridge (ph: 403 329-2747) or e-mail: research.services@uleth.ca.

By signing below, you are indicating that you have read and understood the purposes and nature of this study. You are agreeing to be interviewed on no more than two occasions and know that these interviews will be digitally recorded. You have been given an opportunity to ask any clarification questions you may have prior to participating.

Name of participant (printed)

Signature

Date

Appendix D

Interview guide for Moral Distress Study Participants

Definition of Moral Distress for use with participants at time of interview:

Ethical (or moral) distress arises 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 or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress (Canadian Nurses Association, 2008, p. 6).

Interview Guide (Generic Questions):

1. Can you remember a particular situation that comes to mind from your work related to this definition? Will you share an example with me?
2. Why does that particular moment stand out to you?
3. In the situation you have described, what would the right thing to do have been?
4. Upon reflection of this situation, have you attached any meaning to the situation?

Institutional Questions (Resources, Policy, Systems):

5. Are you able to describe reasons the right thing could not be done in this scenario? For example, what factors do you think prevented you from doing the “right” thing?
6. Are there additional examples of this nature you have encountered?
7. Are the examples you have provided common? If so, does this occur frequently?

Relationship Questions (Power Imbalances, Hierarchical):

8. Do the working relationships among staff members impact instances of moral distress? If yes, how so?
9. Reflecting on the relational factors influencing moral distress within your department, are you able to comment on what is different in the relationships where these situations do not arise?

Appendix E

Participant Demographic Form

For collection at the end of each interview.

Date of Interview: _____

Participant number: _____

Participant Name: _____

Chosen or Assigned Pseudonym: _____

Age of Participant: _____

Gender of Participant: _____

Level of Education: _____

Size of City Currently Employed as ED RN: _____

Years of Experience as ED RN: _____

Number of hours worked per week in your current position as a Registered Nurse in the emergency department: _____