Ethics in **Practice** for Registered Nurses

OCTOBER 2003 ISSN NUMBER 1480-9990

ETHICAL DISTRESS IN HEALTH CARE ENVIRONMENTS

Ethical distress involves situations in which nurses cannot fulfill their ethical obligations and commitments, or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice…

(Webster & Baylis, 2000)

- Jane once loved her practice as a neonatal intensive care nurse but no longer looks forward to going to work. Lately she dreads it. She is uncertain about what has changed for her, but she recognizes that she is increasingly disturbed by the measures used to prolong the fragile lives of extremely premature infants. Jane believes she would never allow such interventions to happen to any child of her own.

- Mai Lee has always enjoyed caring for the elderly, but budget cuts at her facility have meant that she has less and less time for each patient. She feels more like a marathon runner than a nurse most days. Recently, a patient died alone, because no one was able to be with him. Mai Lee knows how frightened this patient was during his last few weeks and feels very distraught about his lonely death. She is also very angry with the institution's administrator who seems to ignore her repeated requests for more staff. Mai Lee does not know what more she can do but feels she is failing her patients.

- Raj became a registered nurse nearly two years ago. When he graduated, he had an image of the professional practitioner he intended to become. Now he finds that he rarely lives up to his idea of a "good nurse." His work at an inner city community health centre should be satisfying, but he finds it frustrating. He blames himself for not making any real difference in the lives of the families in his care. The hardship that he sees in their lives leaves him feeling guilty when he returns to his own comfortable home. Lately he has been having thoughts about a different career.

These nurses are experiencing ethical distress related to their practice.

CANADIAN NURSES ASSOCIATION

ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

WHAT IS "ETHICAL DISTRESS"?

Ethical or moral distress arises when one is unable to act on one's **ethical** choices, when constraints interfere with acting in the way one believes to be right.

The Canadian Nurses Association's (CNA's) *Code of Ethics for Registered Nurses* (2002) defines **ethical or moral**[1] distress as "situations in which nurses cannot fulfill their ethical obligations and commitments (i.e. their moral agency), or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectation of ethical practice, for one or more of the following reasons: error in judgment, insufficient personal resolve or other circumstances truly beyond their control (Webster & Baylis, 2000). They may feel guilt, concern or distaste as a result" (CNA, 2002, p. 6).[2]

CONTENTS

What is "ethical distress"? 2

Why is ethical distress important? 2

What is the difference between an ethical dilemma and ethical distress?. 3

What are some distress signals? 3

What are the sources of nurses' ethical distress? 4

How can nurses respond to an ethically distressing situation? 4

Possible Resolutions to Examples 6

Summary 7

WHY IS ETHICAL DISTRESS IMPORTANT?

The experience of ethical distress may be an expression of the nurse's sensitivity to the moral aspects of practice, including an appreciation of patients' vulnerability and the values embraced in CNA's *Code of Ethics for Registered Nurses* (Lützén, Cronquist, Magnussen, & Andersson, 2003). It can be grounded in recognition of the accountability of nurses and the trust extended to nurses by the public. An experience of ethical distress may encompass an ethical awakening for a nurse and lead to essential improvements in practice (Storch, Rodney, Pauly, Brown, & Starzomski, 2002). The intent should not be to eliminate ethical distress but rather to recognize it and to try to resolve it in the best possible way.

Unresolved ethical distress is linked to "burnout" (Severinsson, 2003; Sundin-Huard & Fahy, 1999) and resignation from nursing positions or nursing itself (Corley, 1995; Corley, Elswick, Gorman, & Clor, 2001; Corley, 2002). (Jane dreads going into the neonatal ICU, and Raj is thinking of finding a different career.) The physical and emotional impact of ethical distress can affect nurses' daily lives. Currently nurses are the sickest workers in Canada, losing more time per year due to illness and disability than any other occupational group (Canadian Institute for Health Information, 2001). Ethical distress is thought to play a role in this (Erlen, 2001; Lützén et al., 2003).

---

1 In this document the terms moral and ethical are used interchangeably based upon consultation with nurse-ethicists and philosophers, while acknowledging that not everyone shares this usage.

2 Megan-Jane Johnstone, an Australian nurse ethicist articulates the following related terms: moral unpreparedness, moral blindness, moral indifference, amoralism, immoralism, moral complacency, moral fanaticism, moral disagreements and controversies and moral perplexity (see Johnstone, M. J. (1999). *Bioethics: A nursing perspective* (3rd ed.). Sydney: Harcourt Australia).

WHAT IS THE DIFFERENCE BETWEEN AN ETHICAL DILEMMA AND ETHICAL DISTRESS?

There is a distinct difference between an ethical dilemma and ethical distress. Ethical dilemmas "are situations arising when equally compelling ethical reasons both for and against a particular course of action are recognized and a decision must be made…" (CNA, 2002, p. 5). Ethical distress, on the other hand, occurs when a decision is made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action. Examples of such barriers might include personal inhibition, co-workers' attitudes, institutional obstacles or circumstances beyond one's control (Fry, Harvey, Hurley, & Foley, 2002; Jameton, 1993; Webster & Baylis, 2000). The nurse perceives an ethical problem, acknowledges ethical responsibility and makes an ethical judgment about the right action. If real or perceived constraints block that action, then ethical distress is likely to be experienced, as the nurse participates in perceived ethical wrongdoing (Nathaniel, 2002).

Jameton (1984; 1993), a philosopher who is credited with creating the term moral distress, identified two types of ethical distress: **initial distress** is "the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values" while **reactive distress** is "the distress that people feel when they do not act upon their initial distress" (p. 544). It is important to recognize that it is the nurse's belief system in concert with the particular situation that leads to ethical distress. One nurse may suffer ethical distress if her elderly patient is resuscitated while another nurse experiences distress if the patient is not. The nurses' beliefs about quality of life and end-of-life issues will shape their response (Wilkinson, 1987/88). Also at issue are nurses' perceptions of the decision-making process to pursue or discontinue treatment, the experience of patients and their families and the activities nurses find themselves doing to implement treatment regimes (Rodney, 1988).

Taking action where possible can reduce the consequences of ethical distress. It may prevent what has been called **moral residue** "that which each of us carries with us from those times in our lives when in the face of ethical distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Baylis, 2000, p. 218). Moral residue may, for example, be an outcome for some nurses who are required to implement behaviour modification strategies in the treatment of mentally ill persons (Mitchell, 2001).

In the example involving Mai Lee, if her efforts to have the administrator of her facility act on the identification of staffing shortages had been successful, Mai Lee would not be experiencing ethical distress. Her ethical distress and resulting moral residue is caused by her sense of failure in changing the situation that forces rationing of nurses' time and that prevents good nursing care. If she finds ways to overcome her sense of not being heard (such as forming a coalition with other nurses and team members to address the issue), she may not experience reactive distress (CNA, 2000).

WHAT ARE SOME DISTRESS SIGNALS?

In describing feelings related to ethical distress, nurses use words like angry, frustrated, depressed, ashamed, embarrassed, heartsick, grieving, heartache, miserable, painful, sad and ineffective (Wilkinson, 1987/88; Holly, 1993; Corley, 2002). A study with military nurses found that, over time, the initial ethical distress led to crying, loss of sleep, nightmares, loss of appetite, feelings of worthlessness, loss of confidence, heart palpitations, changes in body functions and headaches (Fry et al., 2002).

Nurses may not attribute such feelings to ethical distress. In *The Nebraska Nurse*, Pam Barr (1992) describes becoming robot-like following the prolonged death of a patient. Nursing became a job, one that she contemplated quitting. She did not know what was happening to her until she heard about ethical distress at an ethics presentation. "[T]hose two words came to me like someone throwing me a life-preserver. That's what I was feeling" (p. 13). Barr recognized that her patient's death involved so many things that went

against "every thread and fiber of [her] ethical and moral belief[s]" (p. 13). Putting a name to it – to what had felt like an unknown fear – gave her relief.

WHAT ARE THE SOURCES OF NURSES' ETHICAL DISTRESS?

"Traumatic life and death events, multiple role responsibilities, loyalties and expectations as well as maintaining safe and effective care with limited and declining resources may create disturbing personal moral conflicts for the nurse committed to professional excellence" (Fenton, 1988, p. 8). The following major sources of ethical distress have been identified in the nursing literature:

- harm to patients (pain, suffering);
- treatment of patients as objects;
- policy constraints;
- medical prolongation of dying without informed choice;
- definition of brain death;
- inadequate staffing; and
- effects of cost containment (Corley, 2002).

It is the nurse's inability to affect these sources of distress that is most problematic. Just as nurses' ability to influence their work environment is a factor in their efforts to resolve ethical dilemmas (Penticuff & Walden, 2000), lack of control over important aspects of the environment can cause situations leading to ethical distress (Austin, Bergum, & Goldberg, 2003).

Figure one illustrates CNA's model of quality professional practice environments, based on cumulative research, identifies six attributes of healthy workplaces: control over work, nursing leadership, control over practice, support and recognition, professional development and innovation and creativity.

CNA recommends that these attributes be used to determine indicators for accreditation by the Canadian Council on Health Service Accreditation and continues to work in partnership with that organization towards this end. Quality professional practice environments is a primary value central to ethical nursing practice and plays an important role in decreasing the hazards caused by ethical distress and moral residue. Similarly, when nurses have appropriate autonomy, support and opportunities for professional growth in their workplace, there will be fewer barriers to ethical practice and less ethical distress.

HOW CAN NURSES RESPOND TO AN ETHICALLY DISTRESSING SITUATION?

Nurses can

1. ***Recognize*** ethical distress. They can be alert to distress signals and put a name to their experience. Naming ethical distress allows for a greater awareness of what is happening and thus increases possibilities for resolution. Nurses will be less likely to use the negative coping strategies of distancing and escape-avoidance that are often the response to such situations (Sundin-Huard & Fahy, 1999) if they understand the consequences of doing so.

2. ***Refer*** to CNA's *Code of Ethics for Registered Nurses*. The code can help nurses clarify the ethical concerns giving rise to ethical distress. The values of Canadian nurses and the specific responsibilities associated with each value can serve as a guide for reflection and action. The language of the code provides nurses with the words to use in raising the issues with one another and with health team members. "Suggestions for Application of the Code in Selected Circumstances," found in appendix A of the Code of Ethics, may be helpful in determining actions to take. Nurses can also refer to CNA's *Ethics in Practice* for relevant articles such as whistleblowing, futility and working with limited resources.

3. ***Request*** support. Nurses who acknowledge their distress can find relief in discussing their issues with others. This dialogue can be informal or formal. Sources of support include:

   Peers: Talking with other nurses about ethical practice concerns can be a powerful strategy (Storch et al., 2002). It breaks the oppressive silence that keeps the ethically distressed nurse alone in his/her suffering. Nurses need a safe place for such conversations. If their particular health care environment is not conducive to reflective, open dialogue, a neutral place needs to be found. Creating a peer support group with a regular meeting time and place may be particularly helpful. Relief from ethical distress can in some instances result from working with

Figure 1. Quality Professional Practice Environments.

others to advocate for a change in situation (CNA, 2000). Some environments endorse the model of clinical supervision in which nurses mentor one another in practice. Like peer support, this model is based on principles of recovery, empowerment and self-help (Severinsson, 2003). Nurse leaders can offer valuable support, by facilitating dialogue, getting accurate information about the ethically distressing situation and addressing barriers to resolving it. They can ensure that nurses contribute to the development and change of institutional policies.

The Health Care Team: Practitioners together create the moral climate of health care environments. Working towards establishing an ethical culture in which information and one's understanding of that information may be shared, ethical questions can be raised without accusations of being a troublemaker or whiner and conflicts within the team can be addressed is a worthwhile endeavour. Nurses want to be involved in ethical decision-making and know that divergent opinions often can move toward common ground if there is frank and respectful discussion (Sundin-Huard & Fahy, 1999). Strategies like regular case presentations within the interdisciplinary team may support such conversations (Van Soeren & Miles, 2003).

Ethics Committee: Consultation with an ethics committee can help clarify the particular ethical problem, the nurse's responsibility and the barriers to the action the nurse desires. Even if the situation is not resolved as the nurse might hope, being heard and giving testimony helps make sense of events and can be satisfying and healing (Liaschenko, 1995).

Nurses' Associations, Regulatory Bodies and Nurses' Unions: An ethically distressed nurse does not need to feel helpless or alone. Various provincial, territorial and national nursing organizations provide, through their respective mandates, support for nurses in assisting them in working through and resolving distressing situations. Within those groups and within CNA, nurses can find a community of support. There are resources and leadership available to advocate for changes that will safeguard ethical nursing practice. CNA provides such resources as the *Code of Ethics for Registered Nurses*, *Ethics in Practice*, which focuses on a variety of ethical issues, and other resources including its web site.

POSSIBLE RESOLUTIONS TO EXAMPLES

There are actions that nurses like Jane, Mai Lee and Raj can take to help them resolve or alleviate their moral distress. Jane voiced her concerns to the neonatal intensive care unit's clinical nurse specialist. She discovered that she was not alone in her uneasiness regarding the aggressive treatment of very premature infants. With the help of the clinical nurse specialist, Jane raised the issue at the next team meeting. Although there was initially some tension, a frank discussion did occur. Jane was surprised to learn how rapidly the long-term outcomes of such treatments were improving, but she and some others remained deeply concerned about the infant suffering that was involved. The team decided to invite the hospital's clinical ethicist to help them clarify and discuss the issues further. Jane feels good that her concerns were heard and that a dialogue has commenced.

Mai Lee has made an appointment with the practice consultant at her provincial nurses' association to get guidance on how to act on the risks to safe and competent care that are arising at her institution. She found that revisiting the values and responsibility statements in the *Code of Ethics for Registered Nurses* gave her the confidence she needed to act.

Raj is still struggling with the disparity he finds between his vision of the ideal nurse and his daily reality. Recently, however, he has begun to realize that his work at the health centre is making a difference. An elderly patient told him about what things were like in the community before the centre opened. The patient also told Raj about a local citizens' action group that is trying to improve social conditions in the neighbourhood. Raj is planning to attend their next meeting.

SUMMARY

Nurses' commitment to those in their care and to society in general includes providing safe, competent and ethical care. Too often, however, nurses are frustrated in their efforts to enact this professional commitment in ways that are acceptable to them. Barriers to ethical practice lead to ethical distress. If, however, nurses like Jane, Mai Lee and Raj are able to identify their distress as ethical distress, they will be better able to respond to and resolve the situation while learning how to prevent the build up of moral residue.

REFERENCES

Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experiences of moral distress. *Nursing Inquiry*, *10*(3), 177-183.

Barr, P. (1992, February). The unknown fear – Moral distress. *Nebraska Nurse*, 13-14.

Canadian Institute for Health Information. (2001). *Health care in Canada 2001: A second annual report*. Ottawa: Author.

Canadian Nurses Association. (2000, May). Nursing is a political act – The bigger picture. *Nursing Now*, 1-4.

Canadian Nurses Association. (2000, September). Working with limited resources: Nurses' moral constraints. *Ethics in Practice*, 1-4.

Canadian Nurses Association. (2002). *Code of ethics for registered nurses*. Ottawa: Author.

Corley, M. C. (1995). Moral distress of critical care nurses. *American Journal of Critical Care, 4*(4), 280-285.

Corley, M. (2002). Moral distress: A proposed theory and research agenda. *Nursing Ethics, 9*(6), 636-650.

Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33*(2), 250-256.

Erlen, J. (2001). Moral distress: A pervasive problem. *Orthopaedic Nursing, 20*(2), 76-80.

Fenton, M. (1988). Moral distress in clinical practice: Implications for the nurse administrator. *Canadian Journal of Nursing Administration, 1*, 8-11.

Fry, S., Harvey, R., Hurley, A., & Foley, B. (2002). Development of a model of moral distress in military nursing. *Nursing Ethics, 9*(4), 373-387.

Holly, C. (1993). The ethical quandaries of acute care nursing practice. *Journal of Professional Nursing, 9*(2), 110-115.

Jameton, A. (1984). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWONN's Clinical Issues in Perinatal and Women's Health Nursing, 4*(4), 542-551.

Liaschenko, J. (1995). Artificial personhood: Nursing ethics in a medical world. *Nursing Ethics, 2*(3), 185-196.

Lützén, K., Cronquist, A., Magnussen, A., & Andersson, L. (2003). Moral stress: Synthesis of a concept. *Nursing Ethics, 10*(3), 312-322.

Mitchell, G. J. (2001). Policy, procedure and routine: Matters of moral influence. *Nursing Science Quarterly, 14*(2), 109-114.

Nathaniel, A. (2002). Ethics and human rights. *The American Nurses Association Issues Update, 1*(2), 3-8.

Penticuff, J. & Walden, M. (2000). Influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas. *Nursing Research, 49*(2), 64-72.

Rodney, P. (1988). Moral distress in critical care nursing. *Canadian Critical Care Nursing Journal, 5*(2), 9-11.

Severinsson, E. (2003). Moral stress and burnout: Qualitative content analysis. *Nursing and Health Sciences, 5*(1), 59-66.

Storch, J., Rodney, P., Pauly, B., Brown, H., & Starzomski, R. (2002). Listening to nurses' moral voices: Building a quality health care environment. *Canadian Journal of Nursing Leadership, 15*(4), 7-16.

Sundin-Huard, D. & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorising the relationships. *International Journal of Nursing Practice, 5*(1), 8-13.

Van Soeren, M. & Miles, A. (2003). The role of teams in resolving moral distress in intensive care unit decision-making. *Critical Care, 7*(3), 217-218.

Webster, G. & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, M. D.: University Publishing Group.

Wilkinson, J. (1987/88). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29.

Ethics in Practice ***is published by the Regulatory Policy Division of the Canadian Nurses Association (CNA).***

Free copies are available to all CNA members. For additional information and/or additional copies contact CNA Publications.

For more information mail, fax or e-mail:
Canadian Nurses Association
50 Driveway
Ottawa ON Canada K2P 1E2
Telephone: 1-800-361-8404
or (613) 237-2133
Fax: (613) 237-3520
E-mail: info@cna-aiic.ca
Web site: www.cna-aiic.ca

ISSN 1480-9990