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MORAL DISTRESS, LEADERSHIP INTEGRITY, ETHICAL CLIMATE AND TURNOVER INTENT IN CRITICAL-CARE NURSES

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MORAL DISTRESS, LEADERSHIP INTEGRITY, ETHICAL CLIMATE AND TURNOVER INTENT IN CRITICAL-CARE NURSES

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Abstract

MORAL DISTRESS, LEADERSHIP INTEGRITY, ETHICAL CLIMATE AND TURNOVER INTENT IN CRITICAL-CARE NURSES

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Moral distress is a painful psychological imbalance that results from recognizing ethically appropriate action, yet not acting, because of constraints, either real or perceived. Nursing research has focused primarily on clinical situations that cause moral distress, but few studies have explored the influence of nurse leaders and the role of the environment. The purpose of this study was to explore relationships between moral distress experienced by adult critical care nurses and the likelihood of nurses leaving their positions, as well as the moderating effects of these nurses' perceptions of leadership behavioral integrity and ethical climate on intent to turnover. In addition, qualitative data were obtained to gain greater depth and understanding of how critical-care nurses perceive or have experienced moral distress in their work sites.

The Theory of Moral Distress provided the theoretical basis for the study and is designed to clarify what occurs when a nurse either is unable or feels unable to advocate for a patient, and thus experiences moral distress. Nurses, as moral agents, are influenced by nurse leaders and ethical climate, and deal with moral concepts such as commitment,

sensitivity, autonomy, sense making, judgement, conflict, competency, and certainty. When moral distress occurs, the patient, nurse and the organization are impacted. This study focuses on the impact of moral distress on the nurse.

In this mixed methods study, a cross-sectional correlational design was used to determine what, if any, relationships existed between moral distress, perceived leadership integrity, ethical climate, and turnover intent among adult critical care nurses as well as the moderating effect of leadership integrity and ethical climate on moral distress and subsequent turnover intent. In addition, a qualitative descriptive design was used to gain greater depth and understanding of how critical-care nurses perceive or have experienced moral distress in their work sites.

The study population was critical care staff nurses who worked in acute care facilities. The sample population consisted of a convenience sample of American Association of Critical Care Nurses (AACN) members who met the study criteria and agreed to participate in the study. Inclusion criteria for the study were adult critical care staff nurses who provided direct patient care, are members of AACN, were employed full or part-time, have a minimum of one-year experience, and are able to read and write English. Exclusion criteria included critical care nurses working in a managerial role, nurses who have not worked within the past 12 months, pediatric and neonatal intensive care nurses, and those receiving personal counseling due to possible work related psychological issues.

The study found that moral distress and hospital ethical climate have a direct effect on a nurses' intent to leave their position and profession, but the effect of moral distress on intent to leave was not moderated by hospital ethical climate. Also, moral distress and perceived leadership integrity had an effect on a nurses' intent to leave their position and profession but the effect of moral distress on intent to leave was not moderated by perceived leadership integrity. Moral distress frequency scores were moderate; whereas, intensity scores were high which indicated when moral distress indeed occurred in the work environment it caused powerful negative feelings attributed to moral distress.

Chapter One

Overview of the Research Study

Nurses' perceptions of the ethical climate, leadership integrity, and their personal view of how leadership cares about their well-being may serve as buffers to the negative outcomes of moral distress, including decisions to leave their jobs or the profession. A report from the Institute of Medicine (IOM; 2010) calls on nurses to take a greater role in America's increasingly complex health care system. As healthcare reform models begin to lean heavily on nursing for support, it is imperative that all factors precipitating moral distress are recognized and treated to prevent nurse flight from acute care institutions and the profession. Untreated moral distress can result in emotional exhaustion, increased absenteeism, low morale, and job dissatisfaction potentially leading to job turnover, early retirement, and leaving the profession. The purpose of this study was to explore relationships between the levels of moral distress experienced by critical care nurses and the likelihood of those nurses leaving their positions as well as the moderating effect of leadership integrity and ethical climate on moral distress and subsequent turnover intent. The qualitative piece explored the perspectives of nurses that self-identified as having experienced moral distress in the professional work environment.

Introduction to Articles

Guided by a derivation of Corley's Theory of Moral Distress, the program of research focused on moral distress in adult critical care nurses. Using Walker and Avant's (2011) methodology, a concept analysis was performed to examine moral distress and its negative impact on physical and mental health, nurse retention, satisfaction, and the provision of quality patient care. The article also differentiates moral distress from

similar situations which influence the daily challenges of nursing practice. This knowledge will help nurse leaders develop interventions to identify, manage, and resolve situations that cause moral distress. The concept analysis manuscript is presented in Chapter 2 titled *Moral Distress: A Concept Analysis*.

A mixed methods study, titled *Moral Distress, Leadership Integrity, Ethical Climate and Turnover Intent in Critical-Care Nurses,* was subsequently conducted and is presented in Chapter 3. The study used a cross-sectional correlational design to determine what, if any, relationships existed between moral distress, perceived leadership integrity, ethical climate, and turnover intent among adult critical care nurses as well as the moderating effect of leadership integrity and ethical climate on moral distress and subsequent turnover intent. A qualitative descriptive design was used to gain greater depth and understanding of how critical-care nurses perceive or have experienced moral distress in their work sites.

The overall purpose of the mixed methods study was to explore relationships between moral distress experienced by critical care nurses and the likelihood of nurses leaving their positions as well as the moderating effects of these nurses' perceptions of leadership behavioral integrity and ethical climate on intent to turnover. The qualitative piece explored the perspectives of nurses that self-identified as having experienced moral distress in the professional work environment.

Chapter Four provides a summary of this developing program of research. Strengths and limitations of the current study are discussed. Overall recommendations for practice, education, and further research are presented.

Chapter Two

Moral Distress: A Concept Analysis

Abstract

Aim(s) - The purpose of this paper is to differentiate moral distress from similar situations which influence the daily challenges of nursing practice.

Background - Moral distress has been recognized as a practice concern in nursing and health care research for thirty years. Moral distress can negatively impact physical and mental health, nurse retention, satisfaction, and the provision of quality patient care.

Evaluation - A review of moral distress studies in the literature and nurse retention statistics was used to analyze moral distress' impact on nurses.

Key issue(s) - Moral distress must be recognized and addressed in a timely manner to retain nurses.

Conclusion(s) - Unmanaged moral distress can become the next public health crisis and threaten the replenishment of the nation's most trusted profession, professional nursing.

Implications for Nursing Management - Nurse Managers must recognize moral distress and create a healthy work environment where situations that cause moral distress are acknowledged and managed in order to retain nurses.

Keywords: moral distress, compassion fatigue, suffering, negative feelings, retention

The Gallup organization for the past 25 years has organized opinion polls to rate the honesty and ethics of various professions. In 2015, nurses were recognized for the fourteenth consecutive year as having highest honesty and ethical standards of all professions listed (Gallup, 2015). Nurses have topped the Gallup list each year since first included in the poll in 1999, with the exception of 2001, when firefighters were included in response to their work during and after the 9/11 attacks (Jones, 2010). There is a dynamic phenomenon occurring in nursing which can undermine the positive public perception of nurses' as moral agents and concurrently can put the nurse at risk on a personal and professional level. This phenomena is called moral distress and has been recognized as a practice concern in nursing and health care research for thirty years. Moral distress, which often leads to compassion fatigue, can negatively impact mental and physical health, health care provider retention, satisfaction, and the delivery of competent quality patient care.

Because of its significance to nursing and the provision of quality care, truly understanding moral distress is vital. A concept analysis process was utilized to conduct an in depth examination of the concept of moral distress. Methodology included (a) selecting a concept, (b) determining the purpose of the analysis, (c) identifying all uses of the concept, (d) determining the defining attributes, (e) identifying a model case, and (f) defining empirical referents.

Moral Distress: Significance to Nursing

A report from The Institute of Medicine (IOM, 2010) issued a challenge for nurses to practice to the fullest extent of degree preparation and to take a greater role in America's increasingly complex health care system. As future healthcare reform models

begin to lean heavily on nursing for support, it is imperative that all pathways precipitating moral distress are recognized and treated to prevent nurse flight from acute care institutions and the profession. In addition to the emotional toll that moral distress takes on the nurse, actual physical manifestations have been reported. Untreated moral distress can result in emotional exhaustion, increased absenteeism, low morale, and job dissatisfaction, which lead to turnover, early retirement, and flight from the profession. (DeTienne, Agle, Phillips, & Ingerson, 2012; Pauly, Varcoe, Storch, & Newton, 2009).

A projected nursing shortage over the next decade provides additional support to addressing and treating moral distress in nursing. According to Buerhaus, Auerbach, and Staiger (2009) despite a significant reduction in the nursing shortage due to the recession, the United States' nursing shortage was still projected to grow to 260,000 registered nurses by 2025. Additionally, according to the American Nurses Association (2014), over the past decade the average age of employed RNs has increased by nearly two years, from 42.7 years in 2000 to 44.6 years in 2010. The United States is experiencing a population increase in people over age 65, who are potential and likely consumers of health services. This age group has many chronic health care conditions which will place a strain on our health system.

Concept Clarification of Moral Distress

Initially, it is essential to state that the word distress has been defined as unhappiness or pain; suffering that affects the mind and body (Distress, n.d.). The negative aspects of *distress* connote a need to help or save the person in this situation. It also adds urgency to the need to provide relief. The word moral sets the context for the distress. *Moral* is defined as "relating to the principles of right or wrong in behavior;

sanctioned by or operative on one's conscience or ethical judgment" (Moral, n.d.). Most situations of moral distress arise from believing that an action is wrong while being unable to stop or alter it or believing an action is right but being unable to implement it. The inability to make an action fit into the nurse's moral compass causes the distress.

Andrew Jameton (1984), a professor of philosophy and ethics, is recognized as the originator of the moral distress concept. Jameton was interested in issues concerning nurses and through interviews uncovered a repeated theme which he identified as moral distress. Moral distress was described as feelings that are painful, and as a psychological imbalance or disequilibrium that occurs when nurses are in situations where they feel unable to do what is best for the patient. He later enhanced the description to include that moral distress arises when one knows the appropriate actions to execute; however, institutional constraints make pursuit of those actions difficult.

Seven years later, Corley, Elswick, Gorman, & Clore, (2001) extended the definition of moral distress to include the idea that it is "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations" (pp. 250-251).

Nurses who suffer from moral distress report emotional, physical, and psychological symptoms that reduce their self-worth and cause them to withdraw from co-workers, family, and friends (Schluter, Winch, Holzhauser, & Henderson, 2008). Subsequently, moral distress has been found to create a decrease in nursing job satisfaction, high nurse turnover, early retirement, and simply leaving the profession altogether (Epstein & Delgado, 2010; Maningo-Salinas, 2010; Pendry, 2007).

Although the majority of moral distress studies focus on nursing (Corley, 2002; Browning, 2011; Hamric & Blackhall, 2007; Mason et al., 2014; Pendry, 2007; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014), the concept is not exclusive to nursing. In a study of psychologists, Austin (2005) conducted an interdisciplinary qualitative study which explored the moral distress of psychologists working in psychiatric and mental health care settings. Psychologists described specific instances perceived as breakdowns in truthfulness from factors such as institutional pressure, team conflict, and interdisciplinary discord. In addition, Losa Iglesias, de Bengoa Vallejo, & Salvadores (2010) conducted a study with Spanish podiatrists that identified moral distress related to lack of resources, time constraints, and patient demands.

Perhaps closer to nursing in terms of education and clinical experiences, pharmacists and respiratory therapists have also been subject to moral distress. Crnjanski, Krajnovic, Stojkov-Rudinski, & Tadic, 2012) explored moral distress from a pharmacist perspective. Like nursing, pharmacy is a value and knowledge-based profession, in which ethics represents an important aspect of daily work. The study indicated pharmacists' face ethical challenges related to advancements in technology, medicine, and pharmaceutical development. Karen (2006) and Timmer (2014) conducted studies involving respiratory therapists who also are faced with situations that require decisions on the right course of action, and found moral distress related to the perception of unsafe staffing lead to career dissatisfaction, and job turnover.

Related concepts

Moral distress must be addressed and differentiated from similar situations which influence the daily challenges of nursing practice. *Therapeutic obstinacy* is a situation of medical futility which may cause or exacerbate moral distress in nurses. *Positive deviance* may be seen as a nurse reaction to moral distress in an effort to find relief or stability. *Compassion fatigue* may result from continued moral distress and lead to burnout. Each of these terms is related to moral distress.

Therapeutic obstinacy is defined as using therapies that cannot cure the patient, but merely prolong life in harsh conditions (Therapeutic Obstinacy, 2014). It is commonly referred to as medical futility in the literature. Modern medicine has effective methods to prolong life; however, those methods may cause and prolong the suffering of dying patients. These situations cause conflicts in loyalty in the nurse-physician and/or the nurse-family relationship. Nurses take an oath to provide care that is in the best interest of the patient, and prolonging suffering due to the obstinate insistence of a provider or family member seems to countermand the mandate to do no harm. Critical and long-term care nurses who provide care for acute and chronically ill patients on a daily basis may encounter end-of-life and futility issues that invoke moral and ethical dilemmas. Özden, Karagözoğlu, and Yıldırım (2013) reported that suffering repeated experiences of moral distress in intensive care units due to futile practice affects the nurses' ability to provide the best patient care, increases burnout, and reduces job satisfaction. Physicians and family members go home after a patient visit. Nurses feel powerless and are obligated to stay and provide care that may not be in the patient's best interest which over time causes nurses to suffer and display signs of distress.

To counteract the feelings of impotence and the inability to correct the situation, some nurses may take steps to reverse the situation through acts seen as deviating from the standard or ordered protocols for the positive benefit of the patient. Lindberg & Clancy (2010) wrote that positive deviance is predicated on the belief that in most organizations or communities, there are individuals and groups whose different practice or strategies produce better outcomes than do colleagues who have access to the same resources. The positive deviance process helps to explore the deviant's successful practices, and then replicate those practices for the betterment of the community.

Gary (2013) is one of the first nurses to explore the concept of positive deviance in a Delphi study of bedside critical care nurse. The nurses discuss the use of positive deviance in situations where patient care needs were not covered by practice guidelines, standard orders, or when the needs conflict with those guidelines and orders. In this instance, nurses are obligated to do what is right for the patient but must act without clear practice guidelines. In a follow up article Gary (2014) wrote that the nurses must decide to provide patient care with the knowledge that decisions may not be supported by physicians or administrators; these nurses who practice positive deviance must be prepared for the aftermath of consequences.

Compassion fatigue has been defined as a blend of emotional, physical, and spiritual depletion associated with providing care for patients in significant emotional pain and physical distress (Anewalt, 2009; Figley, 1995). Carla Joinson (1992) was one of the first nurse's to write about compassion fatigue and classified it as a type of burnout unique to caregivers. Compassion fatigue is frequently found in the literature of emergency care staff. Thomas, Riegel, Gross, and Andrea (1992) conducted one of the

first research studies exploring burnout and job stress experienced by emergency room nurses. The researchers reported that occupational stress in Emergency Department (ED) nurses influenced absenteeism, job turnover, productivity and satisfaction which are similar outcomes of unresolved moral distress. A more recent study by Hinderer et al. (2014) revealed recurrent exposure to patients with traumatic injuries in a high-pressure environment increases the risk of burnout, compassion fatigue, and secondary traumatic stress in trauma nurses.

Defining attributes of moral distress

Three main attributes evolved to create the concept moral distress in nursing: conflicting loyalties, negative feelings, and powerlessness. These attributes are related, with each retaining exact meaning only when considered within the same viewpoint of one another and with respect to the historic principles of professional nursing practice.

Although nursing maintains patient advocacy as a core value, today's healthcare climate presents nurses with difficult situations that may cause them to experience conflicting loyalties in the caregiver role. Nurses are primarily accountable to patients; however, they are also accountable to families, nurse colleagues, allied health professionals, physicians, employing institutions, licensing bodies, and society as a whole (Corley, 2002). Nurses are charged to examine potential and actual conflicts between their own personal and professional values, the values and interests of others who are also responsible for patient care and healthcare decisions, as well as those of patients. The *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015) reaffirmed that nurses are obligated to assure the primacy of the patient's interests regardless of conflicts that arise between clinicians or patient and family. This is not an easy feat and the

triangulation predisposes a nurse to moral distress when wedged between the patient's wishes and family or provider wishes. Nurses strive to resolve such conflicts in manners that safeguard patient safety, guard the patient's wishes, and preserve the professional integrity of the nurse.

Negative feelings are manifested in the painful and psychological uncertainty of moral distress as anger, frustration, guilt, loss of self-worth, depression, and nightmares that nurses carry from work into their personal lives (Elpern, Covert, & Kleinpell, 2005; Millette, 1994; Cummings, 2011; Wilkinson, 1987). Physical manifestations of moral distress include anger, anguish, anxiety, compromised integrity, dread, embarrassment, frustration, grief, heartache, helplessness, misery, pain, powerlessness, resentment, sadness, shame, sorrow, and suffering (Corley, 2002).

The complex hierarchical structure of health-care systems predisposes nurses to powerlessness and in turn susceptible to moral distress (Oberle & Hughes, 2001; Wilkinson, 1987). Powerlessness comes from not being heard. Redman and Fry (2000) found that a great percentage (33%) of nurses experienced moral distress due to institutional constraints. Example 1: A nurse who struggled with a medical doctor regarding patient care concerns discovered that the organizations did not support the nurse's effort or address concerns. Example 2: Because there is a nursing shortage on the unit, a nurse is forced to work with an unsafe peer who jeopardizes patient safety.

Case of Moral Distress

A nurse in the medical intensive care unit (MICU) arrived on duty to receive a patient assignment which included a 54-year-old female patient with a history of diabetes, hypertension, and end stage chronic obstructive pulmonary disease or COPD.

She had just been extubated and placed on a nasal cannula for oxygenation. Before the nurse could begin a physical assessment, the patient verbalized, “I don’t want that tube back down my throat. I’ve had it four times, and I ain’t scared to meet my maker.” She had a living will in her medical record, and her family knew her wishes. The patient was alert and oriented although her carbon dioxide levels were high, which is common for someone with COPD. She was eventually stable enough to transfer to a telemetry room. The next night, the nurse received notice from the charge nurse that she was receiving an unstable patient from telemetry. It was the COPD patient she transferred out the previous night. As they rolled the patient through the unit, she was flailing her arms attempting to remove her breathing mask screaming, “I don’t want that tube. Don’t give me that tube.” Throughout the course of the night her condition continued to deteriorate. The physician was updated via telephone on the changes in her condition and ordered an arterial blood gas (ABG) level. The family was called and updated on her change in condition. As suspected, her ABG was abnormal. The physician was notified of the results, and fifteen minutes later he arrived on the unit. The nurse informed the physician about the patient’s verbal wish not to be re-intubated, and that she had a living will to that effect. When the family arrived and saw the change in her condition, they asked the physician what could be done. He told them she could be placed back on the ventilator to rest like last time. The family instructed the physician to re-intubate the patient. The nurse reminded the family and the physician of the patient’s wishes. The family member with Power of Attorney stated, “I ain’t ready to let mama go.” The physician told her he was going to put a breathing tube in her mouth, and she fiercely shook her head. Although her carbon dioxide levels were critically high, she had the presence of mind to clamp her mouth

closed and not allow oral intubation, so the physician performed a nasal intubation as the nurse begrudgingly assisted. This case is typical of how moral distress is experienced during the course of a normal day in the nurse's work-life.

Antecedents and consequences

Antecedents are things that must be in place in order for the concept to occur (Walker & Avant, 2010). In order for someone to feel moral distress, the person must have some type of moral compass or standards against which to measure the situation and determine a reaction. This allows the person to recognize the situation as the cause of the distress by identifying it as contradictory to preferred actions. Moral distress is usually precipitated by some type of crisis which requires a decision on action. While the feeling of distress might be ongoing, such as was depicted in the model case by the patient who was forced against her will to have a breathing tube, the incidence of distress was actualized by the crisis moment when the nurse had to face the helplessness of the moment of intubation. Finally, moral distress is often precipitated by a situation which is out of the nurse's hands but for which the nurse feels a certain amount of investment or responsibility. The situation of therapeutic obstinacy is an example of nurses being witness to decisions made by family or physicians which run counter to the moral compass of the nurse whose main role is to benefit the patient. In these situations, nurses are helpless to change the situation but must deal with its aftermath.

Consequences occur as a result of the concept. Moral distress may produce adverse nurse and patient outcomes. There is anecdotal evidence that nurses' moral distress may affect quality of patient care and subsequent health outcomes (Corley, Minick, Elswick, & Jacobs, 2005; Wilson, Goettemoeller, Bevan, & McCord, 2013).

Studies have indicated that certain nurses lost the ability to care for their patient, avoided patient interaction, and failed to provide the appropriate standards of patient care as a result of moral distress (Corley et al, 2005). Some nurses used negative strategies to cope with distress, which included distancing and avoidance that barely met the patient's basic physical needs, or they quit the profession (Corley, 1995; Millette, 1994; Wilkinson, 1987). Some burnout related experiences of moral distress suggested that many nurses leave the profession as a result of the frustration from dealing with recurrent moral distress (Cummings, 2011; Dodek, Wong, Norena, Ayas, Reynolds, Keenan, & Alden, 2016; Lang, 2008; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015; Wilkinson, 1987).

Nurses who suffer from compassion fatigue display emotional, physical, and psychological outcomes similar to moral distress. In both phenomena, the loss of nurses from the workforce is an indirect but compelling threat to patient care. Further analysis of the impact and consequences of moral distress along with interventions to combat negative outcomes are recommended to decrease nurse suffering, preserve nurses' health, and strengthen the profession.

Empirical Referents of Moral Distress

Empirical referents are things that can be used to identify and or/measure a concept in the real world. There are three options to measure moral distress: using a quantifying moral distress instrument to measure nurse perceptions of distress, examining and diagnosing moral distress symptoms, and engaging focus groups or interviews to gain subjective data to identify the depth of identification insights from persons who have reported feelings of moral distress. The Moral Distress Scale (MDS) is a tool that

measures the levels of intensive care nurses' moral distress. Dr. Mary C. Corley developed and evaluated the moral distress scale from 1994 to 1997 using Jameton's conceptualization of moral distress, House and Rizzo's conflict theory, and Rokeach's value theory as a guide (Corley, Elswick, Gorman & Clor, 2001). The MDS was revised into the (MDS-R) by Hamric, Borchers, & Epstein (2012) to be utilized in multiple health care settings and with multiple health care disciplines.

The experience of moral distress is entirely subjective. Moral distress cannot be directly observed nor is it constant. Visual analogue scales (VAS) and verbal numeric rating scales (VNRS) are adaptive instruments that capture subjective phenomena and produce data at the interval level (Foley, 2008). The Moral Distress Thermometer (MDT) is a single item tool with an 11-point scale from 0–10 with verbal descriptors to help determine the level of nurse moral distress over a 2-week period in their practice environment (Wocial & Weaver, 2013).

Moral distress can also be measured qualitatively through focus groups and interviews with nurses who describe their experiences with moral distress. Thompson and Mastel-Smith (2012) wrote about the dilemmas faced by military nurses who cared for enemy insurgents. Their data were gleaned from interviews of nurses who had lived through this experience in Iraq and Afghanistan. The respondents pointed to their moral distress at delivering comparable care for persons who were identified as "the enemy," at the same time knowing they had inflicted many of the wounds on their fellow soldiers. One can speculate that focus groups and interviews which allow the nurse to talk about moral distress may, in fact, be a therapeutic experience in itself in relieving some of the feelings of moral distress.

Conclusion and Recommendations

Nurses are patient advocates, and unfortunately, moral distress causes feelings of frustration from being powerless to provide the appropriate standards of clinical care. Additional research is needed which focuses on the effectiveness of interventions to reduce the untoward effects of moral distress. Corley (2002), one of the early researchers of moral distress, contended that the preceding research had been "limited to instrument development and testing, descriptive findings, and only one intervention study" (p. 648). Several studies have established a connection between moral distress and organizational ethical climates; however, questions regarding this relationship remain. There also appears to be only indirect evidence establishing a concrete relationship between nurses' moral distress and the effects on the quality of patient care and subsequent health outcomes. Interventions are needed to identify, manage, and resolve situations that cause moral distress. If not managed correctly, moral distress can become the next public health crisis and threat to the stability of the nation's most trusted profession, professional nursing.

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Chapter Three

Moral Distress, Leadership Integrity, Ethical Climate and Turnover Intent in Critical-Care Nurses

Abstract

Objectives: To determine what relationships exist between moral distress, perceived leadership integrity, ethical climate, and turnover intent among adult critical care nurses and the moderating effect of leadership integrity and ethical climate on moral distress and subsequent turnover intent; to obtain a richer and fuller understanding of how critical care nurses experience moral distress within the context of critical care work.

Participants: Adult critical care nurse members of AACN (*n=254*), 22-70 years old, recruited February – March 2016.

Methods: A Qualtrics survey posted on the AACN eNewsline included the moral distress scale-revised, perceived leadership integrity scale, hospital ethical climate survey, turnover intent analog scales, and open ended questions to elicit qualitative data.

Results: The direct effects of moral distress and leadership integrity and moral distress and ethical climate on intent to leave position were significant *(R2 = .248, Adj R2 = .241, p < .001; R2 = .256, Adj R2 = .249, p < .001).* The direct effects of moral distress and leadership integrity and moral distress and ethical climate on intent to leave profession were also significant (*R2 = .234, Adj R2 = .224, p < .001*; *R2 = .175, Adj R2 = .165, p < .001*). Neither outcome variable was moderated by leadership integrity or ethical climate significantly.

Conclusion: Hospital ethical climate is a significant independent predicator variable and played a major role in the participants' decision to change their current position and leave the nursing profession.

Keywords: moral distress, ethical climate, leadership integrity, nurse retention, turnover intent

Nurses' perceptions of the ethical climate, leadership integrity, and how leadership cares about their well-being may serve as buffers to the negative outcomes of moral distress, including decisions to leave their jobs or the profession. A report from the Institute of Medicine (IOM; 2010) calls on nurses to take a greater role in America's increasingly complex health care system. As healthcare reform models begin to lean heavily on nursing for support, it is imperative that all factors precipitating moral distress are recognized and treated to prevent nurse flight from acute care institutions and the profession. Untreated moral distress can result in emotional exhaustion, increased absenteeism, low morale, and job dissatisfaction, which in turn may lead to turnover, early retirement, and leaving the profession (DeTienne, Agle, Phillips, & Ingerson, 2012; Pauly, Varcoe, Storch, & Newton, 2009).

A projected nursing shortage over the next decade provides additional support of the need to address the affects moral distress in nursing. Buerhaus, Auerbach, and Staiger (2009) found that despite apparent easing of the nursing shortage due to the recession, the U.S. nursing shortage was still projected to grow to 260,000 registered nurses by 2025. According to the American Nurses Association (ANA) (2014) the average age of employed registered nurses (RNs) has increased by nearly two years, from 42.7 years in 2000 to 44.6 years in 2010. Additionally, America is seeing vast increases in the number of people over 65 who are potential and likely consumers of health services. This age group has many chronic health care conditions that will place a strain on our health system.

Moral distress is a painful psychological imbalance that negatively affects nurses' physical and mental health, job satisfaction, and retention. Moral distress results when

nurses are in situations where they feel unable to do the right thing because of institutional constraints. As a result, some nurses have chosen to leave their position and the profession (DeTienne, et al., 2012; Pauly, et al., 2009; Watson, 2012). Since 2004, the American Association of Critical-Care Nurses (AACN) has recognized moral distress as a significant problem in critical care units across the nation. In response, AACN developed a resource guide to assist critical care nurses in addressing the issues related to moral distress. Titled "The 4A's to Rise Above Moral Distress", the document provided specific guidance to tackle the issue. However, the results of the 2013 AACN Critical Care Nurse Work Environment Survey (as cited in Ulrich, Lavandero, Woods, & Early, 2014) indicate that the health of critical care nurse work environments has declined since 2008. Approximately 21.3% of critical care nurses reported they planned to leave their jobs in the next 12 months and 29.2% in the next 3 years. The options respondents said would very likely influence them to reconsider leaving were better leadership (51.8%), followed by better staffing (48.1%), more respect from administration (47.6%), and more respect from frontline management (47.4%) (Ulrich et al., 2014).

Over thirty years of research has investigated moral distress in nursing in the acute care environment with a major focus on the critical care environment (Dunwoody, 2011; Elpern, Covert, & Kleinpell, 2005; Mason et al., 2014) and end of life situations (Browning, 2013; Piers et al., 2012; & St. Ledger et al., 2013). Nonetheless, critical care nursing turnover rates have not improved. To date, nursing research has focused primarily on clinical situations that give rise to moral distress (Browning, 2011; Corley, 2002; Elpern et al., 2005; Hamaideh, 2014; Maningo-Salinas, 2010; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014), but there are few studies that explore

specifically the nurse leaders' influence on the development of moral distress. Nurse leaders play major roles in creating and maintaining healthy work environments as well as an appropriate moral atmosphere within the organization (Borhani, Jalali, Abbaszadeh, & Haghdoost, 2014). Nurses as moral agents are responsible to serve as patient advocates and speak up when safety and care are compromised. Given that nurses comprise a major part of the healthcare system, healthcare organizations cannot succeed without an effective nursing workforce. This study aims to fill a gap in the literature on the nurse leaders' influence and the effect of the work environment on the development of moral distress.

Mixed method studies are needed to accurately evaluate the occurrence and contributing factors to the development of moral distress. Previously conflicting findings have been reported between quantitative and qualitative studies. For instance, Wilson, Goettemoeller, Bevan, and McCord (2013) reported lower levels and frequencies of moral distress in nursing units but responses to open-ended questions indicated that indeed moral distress was present.

Review of Literature

Moral Distress

The empirical literature on moral distress in nursing and other disciplines has increased dramatically in the last three decades. A keyword search in CINAHL (1984-2016) of the phenomenon of moral distress revealed more than 450 citations. Studies selected as appropriate were those related to adult critical care environments.

The term moral distress is not a word, but an expression that appears to have evolved over the course of time. Merriam-Webster defines moral as relating to principles

of right and wrong in behavior (Moral, n.d.) and distress as pain or suffering affecting the body, a bodily part, or the mind (Distress, n.d.). Jameton (1984) is credited with first identifying the concept of moral distress that he described as feelings that are painful, and as a psychological imbalance or disequilibrium that occurs when nurses are in situations where they feel unable to do the right thing. He further explained that moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.

The development of moral distress carries significant physical and mental consequences. Nurses who experience moral distress report physical, psychological, and emotional symptoms that reduce their self-worth and cause them to withdraw from family and friends (Dickerson, 2011; Schluter, Winch, Holzhauser, & Henderson, 2008). Subsequently, moral distress has resulted in decreased job satisfaction, higher nurse turnover, early retirement, and flight from the profession (Epstein & Delgado, 2010; Maningo-Salinas, 2010; & Wilson et al., 2013).

Ethical Climate

Business has dominated the research literature regarding of ethical climate. Victor and Cullen (1987) first introduced the construct of ethical work climate, which is considered one of many work climate dimensions. Due to an increase in the number of nurses leaving the profession, job satisfaction has become a source of concern and an important issue in nursing studies. A key factor that has not received sufficient acknowledgement, and may assist in explaining the variance in work satisfaction is nurses' perception of the ethical climate in a hospital setting. In the hierarchical structure of healthcare, the position (formal) power of nurses is understood as being beneath that of

healthcare administration and physicians. Nurses may feel a sense of powerlessness, which makes them increasingly susceptible to moral distress (Atabay, Çangarli, & Penbek, 2015; Oberle & Hughes, 2001; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014; Sauerland et al., 2015). Powerlessness comes from not being heard. Redman and Fry (2000) found that 33% of nurses experienced moral distress due to institutional constraints. For example, nurses in conflict with physicians about patient care found that their organizations would not address the problems. The perceived lack of access to ethics committees and organizational disinclination to deal with physicians made these conflicts unresolvable in the nurses' minds (p. 365). Although the concept of ethical climate has been studied extensively in business ethics, ethical climate in nursing is relatively new (Goldman & Tabak, 2010). Several studies have proposed that nurses' positive perceptions of the ethical climate of their organizations are related to higher job satisfaction, organizational commitment and lower nurse turnover (Borhani, Jalali, Abbaszadeh, & Haghdoost, 2014; Pauly, et al., 2009; Sauerland, et al., 2014; Sauerland, et al., 2015).

Leadership Integrity

Nightingale and other early formal nurse leaders gave specific attention to ethics in their writing about ethical responsibilities; however, attention to ethics and nursing leadership has waned over many decades (Makaroff, Storch, Pauly, & Newton, 2014). Given the role of supervisors as enforcers of expectations, "their behavioral modeling… influences employee awareness of expectations for appropriate conduct and compliance with those expectations" (Fritz, O'Neil, Popp, Williams, & Arnett, 2013, pp. 255-256).

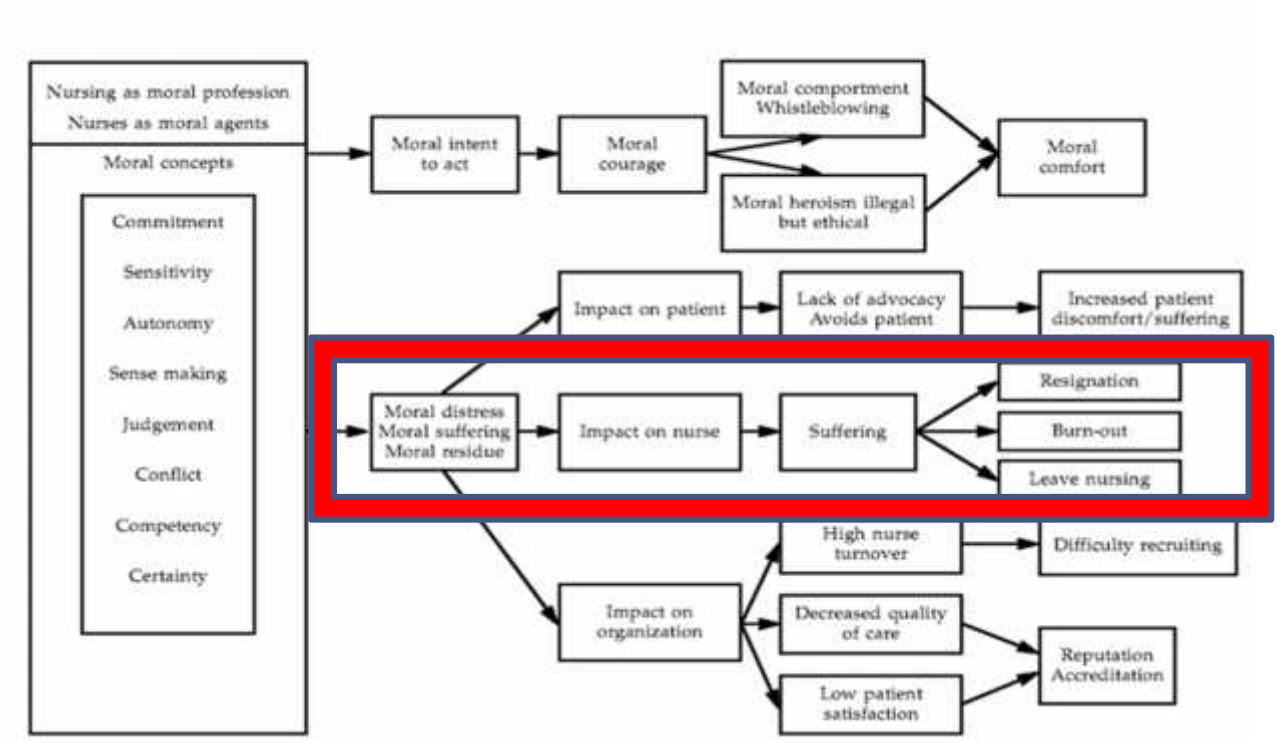
Leaders are held to higher standards and are expected to display conduct that matches expectations.

There is evidence that integrity is related to leader effectiveness. Prottas (2008) reported that organizational outcomes may be affected by the perceptions of employees and that managers should treat employees and customers in a trustworthy and ethical way. Simons (2002) suggested that the difference between espoused and actual values and goals could dissipate employee effort because the employee may not feel they know what it is the manager actually wants. Leroy, Palanski, & Simons (2012) argued that leader integrity drives follower performance. Low perceived leader integrity has been found to lead to role ambiguity, ineffective goal setting and is negatively related to job satisfaction and in-role performance (Eatough, Chang, Miloslavic, & Johnson, 2011; Fritz et al., 2013; Leroy et al., 2012; Palanski & Yammarino, 2011).

Theoretical Framework

The Theory of Moral Distress provided the theoretical basis for the study and is designed to clarify what occurs when a nurse either is unable or feels unable to advocate for a patient, and thus experiences moral distress (Corley, 2002). Nurses, as moral agents, are influenced by nurse leaders and ethical climate, and deal with moral concepts such as commitment, sensitivity, autonomy, sense making, judgement, conflict, competency, and certainty. As illustrated in Corley's Theory of Moral Distress, when moral distress occurs, the patient, nurse, and the organization are impacted. This study focuses specifically on the impact of moral distress on the nurse, which is the portion of the theory outlined in red (see Figure 1). The pain and psychological disequilibrium of moral distress lead to suffering manifested as anger, frustration, guilt, loss of self-worth,

depression, and nightmares, as well as by physical symptoms that nurses carry into their personal lives. Negative feelings and suffering may accumulate over time, and subsequently the nurse may experience burnout and leave the position or even the profession.



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

Figure 1. Theory of Moral Distress

The concepts of leader integrity and ethical climate were identified for this study's derivation of Corley's (2002) Theory of Moral Distress because they are believed to have moderating effects on moral distress and subsequently turnover intent (see Figure 2).

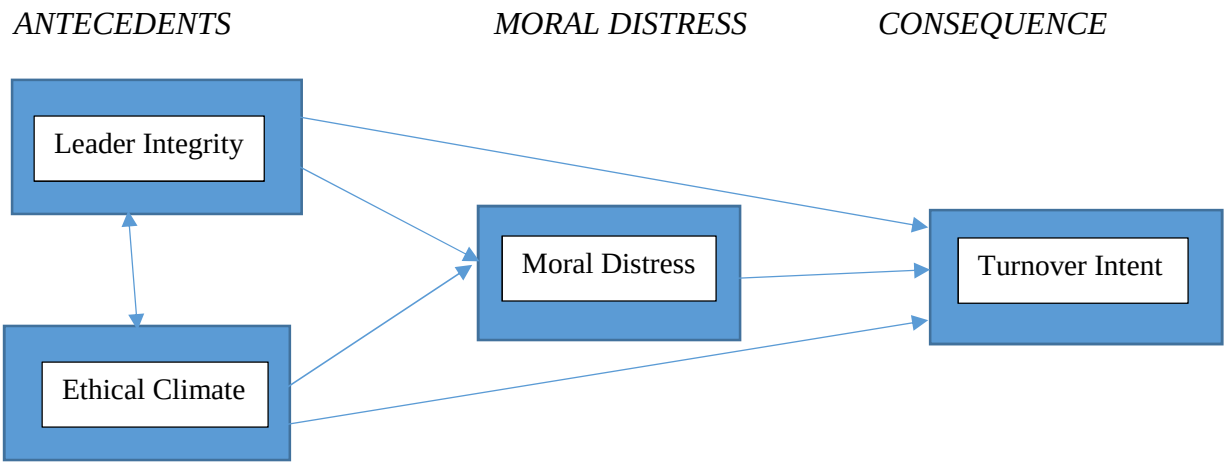


Figure 2. The Derivation of Corley's Theory of Moral Distress Model

Conceptual and Operational Definitions

Table 1

Conceptual and Operational Definitions of Study Variables

Study Variable	Conceptual Definition	Operational Definition
Moral Distress	Psychological pain that results from recognizing ethically appropriate action, yet not taking it, because of obstacles	Moral Distress Scale-Revised (MDS-R) 5 point Likert scale 21 items Rates: intensity - range from 0 (none) to 4 (great extent) & frequency- 0 (never) to 4 (very frequently) Each item frequency score x intensity score. Sum of all item scores = composite score. Scores range 0 – 336. Higher composite scores indicate a higher level of MD Chronbach α = .89
Ethical Climate	Perception of ethically correct behavior & the	Hospital Ethical Climate Survey (HECS)

	way ethical issues should be handled within an organization	5 point Likert scale 26 items Response range - 1 (almost never true) to 5 (almost always true). A higher score indicts a good ethical climate & lower score indicates a poor ethical climate. Chronbach α = .91
Leadership Integrity	Observed pattern between words and deeds	Perceived Leader Integrity Scale (PLIS) 4 point Likert scale 30 item Responses range - 1 to 4 (1 = not at all; 2 = barely; 3 = sometimes; 4 = fairly often) A lower score indicates higher leader integrity Chronbach α = .97
Turnover Intent	How strongly one feels about leaving the organization	2 questions using Visual Analogue Scale (VAS) How likely are you to leave your current position in the next 12 month; and, How likely are you to leave the profession within the next 12 months? VAS anchors: 0 = not considering at all; 50 = have given some thought; 100 = planning to leave

Research Questions

The purpose of this study was to explore relationships between moral distress experienced by critical care nurses and the likelihood of nurses leaving a position or the profession as well as the moderating effects of these nurses' perceptions of leadership behavioral integrity and ethical climate on turnover intent. The qualitative component explored the perspectives of nurses that self-identified as having experienced moral distress in the professional work environment.

Research Questions

1. Among critical care nurses, is the effect of moral distress on intent to leave the position in 12 months moderated by leadership integrity and ethical climate?
2. Among critical care nurses, is the effect of moral distress on intent to leave the profession in 12 months moderated by leadership integrity and ethical climate?
3. How do critical care nurses describe the experience of moral distress at work?
4. How do critical care nurses describe the effect of moral distress on their decision to stay or leave the work setting?

Research Design

In this mixed methods study, a cross-sectional correlational design was used to determine what, if any, relationships existed between moral distress, perceived leadership integrity, ethical climate, and turnover intent among adult critical care nurses as well as the moderating effect of leadership integrity and ethical climate on moral distress and subsequent turnover intent. In addition, a qualitative descriptive design was used to gain greater depth and understanding of how critical-care nurses perceive or have experienced moral distress in their work sites.

Methods

Sample

The study population was critical care staff nurses who work in acute care facilities. The sample population consisted of a convenience sample of American Association of Critical Care Nurses (AACN) members who met the study criteria and agreed to participate in the study. Inclusion criteria for the study were adult critical care staff nurses who provided direct patient care, were members of AACN, were employed full or part-time, had a minimum of one-year experience, and were able to read and write English. Exclusion criteria included critical care nurses working in a managerial role, nurses who had not worked within the past 12 months, pediatric and neonatal intensive care nurses, and those receiving personal counseling due to possible work related psychological issues.

A power analysis was performed to estimate the sample size required for this study. Level of significance was set at $p \leq 0.05$. Sample size was determined for a moderate effect size ($r2 = 0.13$, estimated) and power of 0.80 to avoid a Type II error (Munro, 2005). Sample size utilizing this method demonstrated a need for 157 participants to determine statistical significance.

Informed Consent. Approval to conduct the study was obtained from The University of Texas at Tyler's Institutional Review Board (IRB) for the Protection of Human Subjects (Appendix A) and from AACN (Appendix B) to post a letter of invitation to participate along with the Qualtrics survey link on the Critical Care eNewsline (Appendix C). There are approximately 500,000 critical care nurses in the US, of which over 100,000 are AACN members (American Association of Critical Care Nurses, 2016). The letter of invitation including informed consent form (Appendix, D)

and survey link was included in four editions of the eNewsline from February 3 through March 4, 2016. Those interested in participating in the study accessed the Qualtrics survey via a link on AACNs eNewsline. Although there were no known risks associated with this research study, participants were advised they could become slightly distressed when discussing situations that caused moral distress at the workplace. Participants also were advised that if they felt distressed they could quit the survey at any time. Contact information for the principal investigator (PI), dissertation committee chair, and The University of Texas at Tyler's IRB was included for ease in asking questions or expressing concerns. Consent to participate in the study was implied with completion and submission of the survey.

Measures/Instruments. Using four surveys, the Moral Distress Scale Revised (MDS-R; Hamric, Borchers, & Epstein, 2012), Hospital Ethical Climate Scale (HECS; Olson, 1998), the Perceived Leadership Behavioral Integrity survey (PLIS; Craig & Gustafson, 1998), Visual Analogue Scale for intent to turnover questions similar to those asked by Longo (2009), and a demographic data tool data were obtained for statistical analysis. Permission was obtained to use proprietary surveys prior to study initiation Moral Distress Scale-Revised (Appendix E), Hospital Ethical Climate (Appendix F), and Perceived Leadership Integrity (Appendix G). Two open ended questions were included to obtain qualitative data. The scales, questions, and demographic data tool were combined and entered into Qualtrics®, a survey software platform.

Demographic Data Form. A demographic data collection tool was developed to capture participant age, gender, race or ethnicity, current unit employed, years of experience, and employment status. The tool also captured participant knowledge of

healthcare ethics education, whether their institutions had ethics committees, and whether they had utilized the services of an ethics committee (see Appendix H).

Moral Distress Scale-Revised. In 1995, Dr. Mary C. Corley developed the Moral Distress Scale (MDS) that measured the level of moral distress in critical care nurses. Hamric, Borchers, & Epstein (2012) revised Corley's original moral distress instrument, creating the MDS-R in order to include more root causes of moral distress, expand its use outside the Intensive Care Unit (ICU) setting, and make it applicable for multidisciplinary use (see Appendix I). The 21-item MDS-R consists of two, five-point Likert scales from which participants rate level (intensity) and frequency of moral distress. Frequency options range from 0 (never) to 4 (very frequently); and intensity options range from 0 (none) to 4 (great extent). To calculate the MDS-R score, each item frequency score is multiplied by the intensity score. The sum of all item scores generates a composite score, which could range from 0 – 336. A higher composite score on the MDS-R indicates a higher level of moral distress. Internal consistency reliability was established using Cronbach α (.89). Reliability of the MDS-R in this study was Cronbach's α (.92).

Hospital Ethical Climate Survey. The second tool used in the study was Olson's (1998) Hospital Ethical Climate Survey (HECS; see Appendix J). The 26-item HECS is a unidimensional instrument that addresses five factors reflecting nurses' relationships with peers, patients, managers, physicians, and the hospital. Each item is rated from 1 (almost never true) to 5 (almost always true). Internal consistency reliability, using Cronbach's *a*, was calculated as 0.91. Reliability of the HECS in this study was Cronbach's α (.94).

Perceived Leader Integrity Scale. Craig & Gustafson (1998) developed the 30-item Perceived Leader Integrity Scale (PLIS) to investigate the role of leaders' ethical integrity (see Appendix K). In both a student sample and an organizational field sample, the PLIS demonstrated high internal consistency (Cronbach's $\alpha > .97$) and expected patterns of correlation with other variables (Craig & Gustafson, 1998). Reliability of the PLIS in this study was Cronbach's α (.97).

Turnover Intent. Turnover intent was measured on a visual analog scale (VAS) by two questions regarding nurses' intent to leave (Appendix L). The VAS is a 100-mm line anchored by words or short phrases that determine the intensity or magnitude of intense feelings (Waltz, Strickland, & Lenz, 1991). When compared to the Likert scale, the VAS was found to be a strongly correlated valid measure (Hasson & Arnetz, 2005).

The VAS questions were:

1. How likely are you to leave your current position in the next 12 months?
2. How likely are you to leave the profession within the next 12 months?

Qualitative Inquiry. Two open ended questions were used to gain greater understanding of critical-care nurses' perceptions and experiences of moral distress in the work environment. The questions were:

1. Describe a time you have experienced moral distress at work.
2. Describe an occurrence of moral distress in which you have decided to leave your position. Did you leave, if not, why did you stay?

Data Collection

Following Institutional Review Board (IRB) approval from The University of Texas at Tyler, and with permission from the Director of Professional Practice and

Programs for AACN, an invitation to participate in the study and the Qualtrics survey link were included in the weekly AACN eNewsline in four editions as described above. The survey closed when the required minimum sample size was exceeded. Due to the potentially sensitive nature of the material, participants were encouraged to complete the surveys in a quiet undisturbed place at work or at home. Time of completion of the surveys ranged from 20-45 minutes. Completed surveys were stored in the Qualtrics software system until downloaded into Statistical Package for Social Sciences (SPSS), version 20 by the principal investigator (PI). Data were stored and secured on password-protected computers throughout the duration of the study.

Statistical Analysis

Analysis and interpretation of the both quantitative and qualitative data were undertaken to gain a deeper understanding of the phenomena of interest (Creswell, 2014). Statistical analyses included utilization of descriptive statistics, *t*-tests, analysis of variance, Pearson *r* correlations, and multiple regression with moderating variables. The procedures outlined by Baron and Kenney (1986) guided examination of moderating effects. A two-step multiple regression allowed separation of the main and interacting effects of leadership integrity and ethical climate between moral distress and the outcome variables, intent to leave the position in 12 months and intent to leave the profession in 12 months. Quantitative data were screened prior to analyses in order to address the issues of accuracy of data entry and missing data. Content analysis was used to analyze the qualitative data for recurring themes and patterns that emerged from the narrative responses. Common themes were extracted and coded.

Results

Demographic data collected to describe the sample were analyzed using descriptive statistics. Females comprised 86.6% of the participants. Eighty-four percent were White, 4.2% were Asian, 1.5% were Hispanic/Latino, 3.4% were Black, and 3.8% were of 2 or more ethnic backgrounds. These numbers mirror national registered nurse statistical data by race. The majority of participants, 61.5%, held a baccalaureate degree in nursing, followed by associate degree 22.1%, diploma degree, 6.9%, and other degrees 6.5%. The majority (77.5%) were employed full-time. Thirty seven percent worked at Magnet designated facilities. Type of units worked varied, with the majority reporting Medical ICU, 44.9%, Cardiovascular ICU, 18.1%, Surgical ICU, 15%, and Coronary Care, 8.7%. Eight respondents failed to enter information in Qualtrics. (See Table 2).

Table 2

Demographics Profile

		N	%
Gender			
	Male	28	10.7
	Female	227	86.6
Race/Ethnicity			
	Asian/Pacific Islander	11	4.2
	Black	9	3.4
	White	221	84.4
	Hispanic	4	1.5
	2 or more racial or ethnic backgrounds	10	3
Educational Background			
	Diploma in Nursing	18	6.9
	Associate Degree in Nursing	58	22.1
	Bachelor of Science in Nursing	161	61.5
	Other	17	6.5
Employment Status			
	Full-time	203	77.5
	Part-time	40	15.3
	Supplemental/PRN	12	4.6
Current Work Unit			

	Coronary Care	22	8.4
	Cardiovascular Intensive Care	46	17.6
	Medical Intensive Care	114	43.5
	Surgical Intensive Care	38	14.5
	Shock Trauma Intensive Care	12	4.6
	Neurological Intensive Care	17	6.5
	Burn Intensive Care	5	1.9
Magnet Status			
	Magnet	95	36.3
	Non-Magnet	159	60.7

Ages ranged from 22 to 70 years with a mean of 43.8 years. Total years worked as a critical care nurse ranged from 1 to 45 years with a mean of 13.76 years. Length of employment at current hospital ranged from 1 year to 35 years. (See Table 3).

Table 3

Age and Years of Experience

	N	Range	Mean
What is your age?	247	22-70	43.87
Total # of years worked as a critical care nurse.	239	1-45	13.76
Total # of years worked as an RN.	242	1-50	16.03
How long have you been employed at your current hospital (report to the closest year)?	231	1-35	12.24

Parametric Statistics

Study results met the assumption for parametric statistics (normality, collinearity, and bias) with the exception of homoscedasticity. Visualization of the scatter plots revealed patterns in a rectangular shape as opposed to random dispersion. Although not funnel shaped, the dispersion may represent a violation of homoscedasticity for both outcome variables. To account for the potential violation of the assumption of homoscedasticity in all of the regressions, the bootstrap procedure was performed to increase confidence in the results and allow for population generalization.

Research Question 1

Research Question 1: Among critical care nurses, is the effect of moral distress on intent to leave the position in 12 months moderated by leadership integrity and ethical climate?

Leadership Integrity. This analysis included data from 220 participants who completed instruments measuring moral distress (predictor), leadership integrity (moderator), and intent to leave position in 12 months (outcome). Both moral distress and leadership integrity have a direct effect on intent to leave position (see Table 4, Step 1), but the effect of moral distress on intent to leave is not moderated by leadership integrity (see Table 5). Step 1 consisted of entering the main effects of moral distress and leadership integrity into a regression equation (R^2 = .248, Adj R^2 = .241, p < .001). Step 2 was analysis of the interaction term, the product of moral distress (centered) and ethical climate (centered), (R^2 = .253, Δ R^2 = .005, p = .223). Step 1 is the best model reflecting the main effects of moral distress and leadership integrity on nurses' intent to leave the position in 12 months. Examination of the individual contribution of the main effects reveals that moral distress and leadership integrity have a significant impact on the nurses' intent to leave the position but leadership integrity is a better predictor (β = .380) than moral distress (β = .213) (see Table 4). The bootstrap procedure does not support generalizability of the model representing main effects of moral distress and leadership integrity at a 95% CI [-9.84, 17.8].

Table 4

Test of the Moderating Effect of Leadership Integrity Between Moral Distress and Nurses Intent to Leave the Position in 12 Months

Predictor variable	R^2	Δ R^2	*F* Chg.	*B*	*SE B*	*t*	Beta	Descriptives Mean	Descriptives Std. Dev.
Step 1	.248	.248**	37.79	4.35	6.97	.623**			
Moral Distress				.09	.03	3.29*	.213	228.67	78.18
Leader Integrity				.55	.09	5.87**	.380	53.67	23.51
Step 2	.253	.005	1.49	3.02	7.05	.429**			
Moral Distress				.095	.03	3.35*	.217		
Leader Integrity				.59	.098	5.98**	.404		
.Moral Distress X Leader Integrity				-.001	.001	-1.221	-.078	651.68	1911.6

Note. $n = 220$
*$p < .05$; **$p \leq .001$

Table 5

Turnover Intent Position – Change Statistics Leadership Integrity & Moral Distress

Predictor Variable	Change Statistics df2	Change Statistics Sig. F Change	Durbin-Watson
Step 1	205	.000	
Leader Integrity Moral Distress			
Step 2	204	.223	
Leader Integrity Moral Distress LI X MD			2.055

Dependent Variable: Visual Analogue Scale – Intent to Turnover position in the next 12 months.

Ethical Climate. This multiple regression analysis also included data from the same 220 participants who completed instruments measuring moral distress (predictor),

ethical climate (moderator), and intent to leave position in 12 months (outcome). Both moral distress and hospital ethical climate have a direct effect on intent to leave position (see Table 6, Step 1), but the effect of moral distress on intent to leave is not moderated by hospital ethical climate (see Table 7). Following the same procedure, a two-step multiple regression allowed separation of the main and interacting effects of leadership integrity and ethical climate between moral distress and the outcome variables, intent to leave the position in 12 months and intent to leave the position in 12 months. Step 1 consisted of entering the main effects of moral distress and ethical climate into a regression equation ($R^2 = .256$, Adj $R^2 = .249$, $p < .001$). Step 2 was analysis of the interaction term, the product of moral distress (centered) and ethical climate (centered), ($R^2 = .262$, $\Delta R^2 = .006$, $p = .199$). Results support the influence of the main effects on nurses' intent to leave the position in 12 months but do not support the moderating effect of ethical climate between moral distress and the nurses' intent to leave their position. Examination of the individual contribution of the main effects reveals that both have a significant impact on the nurses' intent to leave the position ($\beta = .14$) but is the better predictor for hospital ethical climate ($\beta = -.419$) (see Table 6). The bootstrap procedure supports generalizability of the model representing main effects of moral distress and ethical climate at a 95% CI [88.9, 157.6].

Table 6

Test of the Moderating Effect of Ethical Climate Between Moral Distress and Nurses Intent to Leave the Position in 12 Months

Predictor variable	R^2	Δ R^2	*F* Chg.	*B*	*SE B*	*t*	Beta	Descriptives Mean	Descriptives Std. Dev.
Step 1	.256	.256**	37.33	123.49	17.90	6.89**			
Moral Distress				.06	.03	2.07*	.14	228	78.39
Ethical Climate				-.96	.16	-6.16**	-.419	85.59	14.83
Step 2	.262	.006	1.66	124.73	17.91	6.97**			
Moral Distress				.07	.03	2.28*	.157		
Ethical Climate				-.98	.16	-6.26**	-.428		
.Moral Distress X Ethical Climate				.00	.002	1.287	.078	-591.7	1338.62

Note. $n = 220$
*$p < .05$; **$p \leq .001$

Table 7

Turnover Intent Position – Change Statistics Ethical Climate & Moral Distress

Predictor Variable	Change Statistics df2	Change Statistics Sig. F Change	Durbin-Watson
Step 1	217	.000	
Ethical Climate Moral Distress			
Step 2	216	.199	
Ethical Climate Moral Distress EC X MD			1.944

Dependent Variable: Visual Analogue Scale – Intent to Turnover position in the next 12 months?

Research Question 2: Among critical care nurses, is the effect of moral distress on intent to leave the profession in 12 months moderated by leadership integrity and ethical climate?

Leadership Integrity. This analysis included data from 173 participants who completed instruments measuring moral distress (predictor), leadership integrity (moderator), and intent to leave profession in 12 months (outcome). Both moral distress and leadership integrity have a direct effect on intent to leave profession (see Table 8, Step 1), but the effect of moral distress on intent to leave is not moderated by leadership integrity (see Table 9). Step 1 consisted of entering the main effects of moral distress and leadership integrity into a regression equation (R^2 = .234, Adj R^2 = .224, p < .001). Step 2 was analysis of the interaction term, the product of moral distress (centered) and leadership integrity (centered), (R^2 = .235, Δ R^2 = .001, p = .604). Results support the influence of the main effects on nurses' intent to leave the profession in 12 months but do not support the moderating effect of leadership integrity between moral distress and the nurses' intent to leave their profession. Examination of the individual contribution of the main effects reveals that only leadership integrity (β = .350) had a significant impact on the nurses' intent to leave the profession (see Table 8). The bootstrap procedure supports generalizability of the model representing main effects of moral distress and leadership integrity at a 95% CI [-32.16, -7.16].

Table 8

Test of the Moderating Effect of Leadership Integrity Between Moral Distress and Nurses Intent to Leave the Profession in 12 Months

								Descriptives	
Predictor variable	R^2	Δ R^2	*F* Chg.	*B*	*SE B*	*t*	Beta	Mean	Std. Dev.
Step 1	.234	.234**	24.28	-20.49	6.91	-2.97**			
Moral Distress				.09	.03	2.95*	.223	228.4	78.2
Leader Integrity				.45	.097	4.63**	.350	53.7	23.2
Step 2	.235	.001	.27	-21.2	7.06	-3.00**			
Moral Distress				.09	.03	2.97*	.255		
Leader Integrity				.47	.10	4.55**	.363		
.Moral Distress X Leader Integrity				-.001	.001	-.519	-.039	717.5	1951.2

Note. $n = 173$
$^*p < .05$; $^{**}p \leq .001$

Table 9

Turnover Intent Profession – Change Statistics Leadership Integrity & Moral Distress

Predictor Variable	Change Statistics		Durbin-Watson
	df2	Sig. F Change	
Step 1	159	.000	
Leader Integrity Moral Distress			
Step 2	158	.604	
Leader Integrity Moral Distress LI X MD			1.804

Dependent Variable: Visual Analogue Scale – Intent to Turnover profession in the next 12 months

Ethical Climate. This analysis also included data from the same 173 participants who completed instruments measuring moral distress (predictor), ethical climate

(moderator), and intent to leave profession in 12 months (outcome). Both moral distress and hospital ethical climate have a direct effect on intent to leave profession (see Table 10, Step 1), but the effect of moral distress on intent to leave is not moderated by hospital ethical climate (see Table 11). Step 1 consisted of entering the main effects of moral distress and ethical climate into a regression equation (R^2 = .175, Adj R^2 = .165, p < .001). Step 2 was analysis of the interaction term, the product of moral distress (centered) and ethical climate (centered), (R^2 = .175, Δ R^2 = .000, p = .853). Results do not support the influence of the main effects on nurses' intent to leave the profession in 12 months nor support the moderating effect of ethical climate between moral distress and the nurses' intent to leave their profession. Examination of the individual contribution of the main effects reveals that neither have a significant impact on the nurses' intent to leave the profession (see Table 10). The bootstrap procedure supports generalizability of the model representing main effects of moral distress and ethical climate that can also be seen in Table 10 Step 1 the 95% CI [10.07, 86.27].

Table 10

Test of the Moderating Effect of Ethical Climate Between Moral Distress and Nurses Intent to Leave the Profession in 12 Months

Predictor variable	R^2	Δ R^2	F Chg.	B	$SE\ B$	t	Beta	Descriptives Mean	Descriptives Std. Dev.
Step 1	.175	.175**	17.92	47.33	19.28	2.46**			
Moral Distress				.08	.03	2.56*	.216	227.96	78.69
Ethical Climate				-.50	.17	-3.01**	-.255	84.71	15.07
Step 2	.175	.000	.035	47.3	19.34	2.45**			
Moral Distress				.08	.03	2.40*	.212		

Ethical Climate	-.498	.17	-2.98**	-.254		
.Moral Distress X Ethical Climate	.000	.002	-.186	-.014	672.01	1394.66

Note. $n = 173$
*$p < .05$; **$p \leq .001$

Table 11.

Turnover Intent Profession – Change Statistics Ethical Climate & Moral Distress

Predictor Variable	Change Statistics df2	Sig. F Change	Durbin-Watson
Step 1	170	.000	
Ethical Climate Moral Distress			
Step 2	169	.853	
Ethical Climate Moral Distress EC X MD			1.804

Dependent Variable: Visual Analogue Scale – Intent to Turnover profession in the next 12 months?

Qualitative

Qualitative data were obtained from the participants' responses to two open-ended questions included in the Qualtrics survey. The qualitative data were analyzed through descriptive coding and thematic analysis. After copying data into one transcript, the data were read line by line repeatedly. To fully grasp the essence of the responses, the following questions were considered of the data: 1) in what category does this incidence fall? and, 2) What is actually happening in the data? The six sources of moral distress that emerged were physicians, peers, nurse leaders, end-of-life situations, and patients' families. Data were then categorized by the source of moral distress and again analyzed line by line for greater understanding. Connections between overlapping themes required a fourth data analysis with redistribution of content to prevent repetitive findings. Powerlessness was the emergent theme extracted from the qualitative submissions.

Analysis of the now categorized data revealed recurrent cluster themes of frustration, feelings of inadequacy, mistrust, disrespect and vulnerability led all to feelings of powerlessness in this group of respondents.

Question # 1 Describe a time you have experienced moral distress at work?

Participants provided over 150 personal experiences of moral distress at work. The emergent theme of powerlessness and its six cluster themes: frustration, inadequacy, mistrust, vulnerability and disrespect came from five sources: end-of-life situations, nurse leaders, patient family members, peers, and physicians.

Frustration

Nurses are taught to be patient advocates but advocacy proves difficult and frustrating when nurses feel they are not being heard or perceive that their opinions do not matter. Nurses feel the resulting powerlessness makes them increasingly susceptible to moral distress. Recurrent responses regarding end of life situations were generated by interactions with patient family members and from physicians. Frustration from family members resulted from unrealistic expectations related to prognosis and quality of life. Frustration generated from physicians was twofold: 1) Failing to engage in appropriate futile care conversations with family members, and 2) Failure to initiate end-of-life care orders and comfort measures for futile cases.

There were two underlying issues that permeated from these stories which involve the nurses' personal attitude towards the value of time at the patient's bedside and the patient's quality of life. Regarding the nurse's perception of time at the bedside, physicians and families essentially have the prerogative to enter and exit the patient's room throughout the course of the day. Physicians, by the nature of their job, have 24 hour patient accessibility while the families must follow the hospitals' visitation policy;

however, nurses provide bedside care twenty-four hours a day, seven days a week. Nurses expressed frustration with being left to provide care dictated by families or physicians that they knew was against the patient's wishes, futile, or perceived to be unethical. Participants shared numerous examples where families along with physicians revoked patient advanced directives and Do Not Resuscitate (DNR) orders. One nurse shared the following story, "Day after day, I had to look at the pain in the eyes of a terminally ill patient that mouthed 'Let me die'around a breathing tube because their DNR was rescinded by a family member who never visits". The nurses wish the family and physicians would recognize and be sensitive to the patients' dignity, pain control needs, and wishes.

The second issue was quality versus quantity of life. Nurses expressed frustration about providing care that caused undue pain for patients that met criteria for comfort care measures and for carrying out futile measures. The nurses expressed frustration with physicians that gave family members false hope or those that did not give the family members a realistic picture of the patient's prognosis. Nurses hear the moans and groans, see the shedding of tears, and smell the signs of infection and the decomposition processes. For example, a nurse shared the experience of providing care for a patient with foul smelling rotting flesh, in organ failure, and kept alive on the ventilator because the physician gave the family "false hope". Another nurse shared that she performed CPR on a frail end stage cancer patient that had "made peace with the Lord and was ready to go home". The nurse ended up breaking ribs during chest compressions for cardiac arrest. In many of these previous entries the family members failed to visit the patients during the latter stages of their hospital stay.

Inadequacy

Feelings of inadequacy come after frustration. Nurses are taught and expected to be patient advocates and to keep the patients safe. Because critical care nurses work in environments where traditional patient care is merged with advanced technology that assists with monitoring and life support, nurse are often held to higher practice standards. The standards often include the ability to critically think, make quick decisions that meet patient care standards, assemble and maintain life saving devices, care for high acuity patients, and provide family support simultaneously. These standards are the hallmark of the adult critical care environment where specialty trained nurses' care for the sickest of the sick in acute care institutions. The higher practice standards are not frowned on but embraced, as they signify the trust of competence and skill level that is bestowed upon the nurses caring for critically ill patient.

It is considered a badge of honor to not have a "code blue or death on my shift" often verbalized as "Keep 'em alive til 7:05", said one nurse. When patients can speak for themselves and are of sound mind and body, it is a win-win situation. In ideal situations goals are discussed, established, and re-evaluated between the nurse, the patient, and healthcare team. When patients cannot speak for themselves, nurses must rely on advanced directives or family accounts of the patient's wishes. Nurses felt most inadequate when rendered voiceless to advocate for patients with documented advanced directives and when placed in "unsafe" staffing situations where they felt unable to give patient care that met patient care standards.

There were over thirty responses related to caring for patients who had Do Not Resuscitate (DNR) paper work overturned by family members or physicians. One

particular story involved a nurse whose patient happened to be a retired nurse. The nurse wrote, “She was very sick, trached but could communicate by mouthing. She asked on multiple occasions to die. Stated ‘I don’t deserve this. I want to die!’ Husband and MD said she was confused. She could tell me about the drugs she was on, she could tell me the month. She was ’with it’ enough to make those kinds of decisions.” This nurse advocated on behalf of the patient to the husband and physician to no avail and left work feeling inadequate because she was not able to successfully honor her patient’s wishes. The nurse’s pain was palpable in her words.

Unsafe and short staffing situations perceptions were a second recurring cause for feelings of inadequacy. To provide safe and quality care for high acuity patients’ with or without advanced life support technology, adult critical nurse must have lower nurse patient ratios compared to medical-surgical nurse peers. A patient receiving life-saving intravenous medications or advance technological management can require frequent adjustments to maintain hemodynamic balance and require the nurse’s undivided attention. A high acuity or complex patient can require a 1:1 or sometimes 2:1 nurse patient ratio to provide a safe standard of care. The high volume of staffing concern responses provided showed that unsafe staffing was of great concern to the respondents. One nurse shared,

> “When I have three patients in the ICU with little or no help readily available, it causes me a huge amount of moral distress. I am unable to provide but the most basic patient care which generally consists of passing medications and trying to keep then turned. I hate telling a patient that is laying in stool that they will have to wait for help.”

Another nurse shared that she was providing care for a patient who required a nurse-patient ratio of 1:1 but was given a second patient and told to "just throw some VS in every once in a while." She stated, "She felt she failed the 2nd patient". Another nurse summed it up nicely when she said that "we work with people not widgets and they deserve our utmost attention and care".

Mistrust

The hierarchical nature of the nursing profession creates a perfect environment for powerlessness when there is a mistrust of leadership. It has been hypothesized that those organizations with a positive professional practice environment, characterized by healthy and respectful nurse-physician relationships, are better able to recruit and retain the best nurses and contribute to a better patient environment (Galletta, Portoghese, Battistelli, & Leiter, 2013). Physicians have traditionally been considered the patient care leader and their expertise helps shape the action plan and course of treatment. A good physician leader sets the vision and tone for the team. Nurses are accountable to provide patient care as prescribed by the physician, and, trust that physicians will do no harm to the patient and apply ethical principles to provide safe care. However, nurses also have a duty to the patient and have a right to refuse physician orders if the orders are perceived as not in the patients' best interest.

Acute care institutions organizational matrices vary; however, traditionally the nurse director or nurse manager is considered the "voice of nursing" and advocates to administration on behalf of nurses. Nurse directors and managers also address patient issues, staff concerns, medical staff relationships, organizational initiatives, but most importantly, are accountable to ensure that nurses have the tools and resources to provide

appropriate patient care. Nurses trust and depend on the director or manager to create healthy work environments that place patient and staff safety at the forefront.

It has been established that safety and the quality of care patients receive depend upon the quality of the healthcare practice environment where care is provided. Once it is perceived that a physician or nurse manager is untrustworthy, nurses feel powerless and unsupported which leads to mistrust. Multiple responses were received on perceived physician dishonesty and unethical care as well as lack of support from nursing directors and managers regarding healthy work environments and patient safety concerns.

The majority of responses related to physician mistrust involved cardiovascular and neuro surgeons and their "God complex". One nurse defined the God Complex as when "the physician refuses to give up even when treatment is futile." There were several related responses that stated the physicians, "Threw the nurses under the bus," when there were bad patient outcomes. The nurses were of the opinion, "That care was futile and the patients' should have never been surgical candidates". The patients' "survived" the surgery but died in the unit. One nurse in particular shared, "A CV surgeon lied to patient about condition and surgery. Patient did not do well and died shortly after. Family liked surgeon and believed every word he said. Family blamed nurses for death even though the patient received excellent nursing care".

A neuro ICU nurse shared the following story which she perceived as being dishonest to the family. "Moral distress is greatest for me when providers give conflicting information to families, particularly when the patient is in grave condition. We had a 27 year old with massive, terminal head injury and the neurosurgeon was telling the family, 'he looks good' and my favorite, 'he may walk with a limp', when we all knew he would

not survive the injuries. So when the nurses were put in a position of telling the truth we became the enemy because we were all telling them different stories".

An important measure of hospital quality is the incidence of unplanned or unexpected readmissions. An unexpected readmission can be perceived by healthcare insurance agencies as an acute care institutions' failure to adequately equip a patient for success post discharge. Subsequently, acute health care institutions are not reimbursed for select patient populations readmitted within thirty days of discharge. There were several respondents with perceptions that patient care was driven by the "30 day window". For example, a patient with poor baseline status with Guillian Barre had an aortic valve replacement (AVR) and an abdominal aortic aneurysm (AAA) repair. The patient did very poorly after surgery. "Rather than a palliative care approach, I felt like the patient was trached and pegged just so could make it to the 30 day survival window. The patient's husband had claustrophobia and found it difficult to visit his wife and therefore did not understand the severity of the situation. When I started discussing the long term outlook with the family, they were shocked".

Surprisingly, lack of support was the major concern that caused nurses to mistrust nursing leadership which is a major responsibility of their role. A number of responses contained unaddressed or unresolved patient safety (patient load-acuity and staff competence) issues. Nurses shared the following stories. "Arrived to work, the acuity called for 5.7 nurses to care for the current census. There were only 3 nurses. Immediately we were to take an admit from the ED. The staffing was extremely unsafe. I was not able to give safe care. All members of the Executive Management Team were aware. No additional staff provided". "Managers are not about patient care and do not

care about patient outcome. Is all about the patient satisfaction survey". "Nursing leadership supports physician @ the expense of nursing (e. g. requires RNs to document core measures, MDs/NPs/PAs have NO responsibility)". "We have poor morale and very high turnover because we do not have support from our leadership team".

Finally, mistrust related to peer interactions stemmed from themes of bullying, lateral, or horizontal violence from peers and nurse leaders. Bullying in the nursing world involves recurrent, offensive, abusive, intimidating, or insulting behaviors; abuse of power; or unfair sanctions that make recipients feel humiliated, vulnerable, or threatened, thus creating stress and undermining their self-confidence (Embree & White, 2010; Hutchinson, Wilkes, Jackson, & Vickers, 2010). Bullying was one of the major factors in this study that caused nurses to leave a position. Participants shared that the thought of coming into work each shift to be bullied by "your own" was unbearable. Nurses offered the following examples of bullying behaviors encountered in the work environment. "Being insulted and yelled at by a fellow nurse who did not agree with my use of an assessment tool". "Being bullied by another employee for something they think I did but never came to me about it. They assumed and reacted towards me". "Gossiping and cliquishness between nurses on my floor". "Nurse sabotage. Nurses reporting false things to nurse manager about me". "Hostile work environment". "Horrible manager that was trying to get all the senior staff to leave. She was manipulative and pinned staff against one another". "Involved in a code situation where other senior nurses bullied me to not fill out an incident report". "My manager told me that I was not to talk about healthy work environment standards on our unit because it would make others angry".

Many were also perplexed with how a profession known for its caring practice could be so "clickish", unsupportive, and unwelcoming to each other.

Vulnerability

Vulnerability, related to job security, was a recurrent theme and served as a reason that nurses did not speak up about moral distress caused by physicians and nurse leaders. "I don't want to rock the boat. I need my job". Nurses who felt vulnerable shared that they were single parents, in debt, "too old" to find a new job, or the hospital was the only stable employer remaining in town. One nurse shared, "I just try to stay under the radar and stay on the boss's good side. I don't want to cause any waves".

Several respondents stated the pursuit of an advanced nursing degree was their "way out". They were enrolled in nurse practitioner and nurse educator programs. There were some that were "holding on" for retirement and others that considered relocation or stepping down from their current position. A great number of respondents chose to "escape" by going "PRN" status to work on an as needed basis for the hospital. Interestingly, several respondents were realtors or seeking realtor certifications which is a potential exit route from the profession.

Disrespect

In the latest annual Gallop survey, the public ranked nurses with the highest honesty and ethical standards (Gallop, 2015); however, the nurse respondents did not perceive a high level of respect from physicians and nurse leaders. There are feelings of powerlessness related to not respecting bedside nurses' observations and opinions. There were recurrent patterns of "physicians hearing but not listening to nurse concerns", which eventually turned into adverse patient outcomes. Nurses shared stories of how they

watched patients' health conditions deteriorate before their eyes because the physician did not acknowledge, support, or act on the nurses' assessment findings resulting in the nurse performing heroic measures including practicing outside their scope of practice. The participants provided both passive and active examples of physician disrespect towards nurses. In one entry a physician berated nurses by calling them, "Stupid" for following another physician's order in front of peers and patient family members. The offending physician failed to respond to the nurse's call in a timely manner so she called another physician to get the orders she felt she needed to keep her patient safe. Another nurse wrote about being, "Cursed out… and called profane names with the use of profane language for questioning an order" even though a nurse has an ethical and legal right to question an order they feel is inappropriate or could cause detriment to the patient.

Nurses also felt disrespect from nurse leaders, their voice in the healthcare setting, which was perceived as the worst form of betrayal. Nurses felt disrespect from ineffective nurse leader support. For instance nurse leaders failed to petition Executive Leadership in situations involving workplace bullying and physician complains regarding nursing care and performance. Several nurses verbalized that hospital leaders, which included nurse leaders, received bonuses while units were unsafely staffed and ill-supplied. "They said the hospital made money but we don't have the supplies we need and we always work short". "The nurse manager makes us run lean so she can get her bonus". "We were 3 nurses short and my manager yelled and said get out of my office, suck it up that's all we have". "The CNO walked through the unit looking for empty beds and did not speak. The beds are not the problem. It's the staff to man them". "I want to see them care for 3 ICU patients." Nurse leader disrespect appeared to be a major factor

when nurses decided to look for new positions. One nurse shared, “Really bad management that does not support their staff causes burnout and high turnover”. Question # 2: Describe an occurrence of moral distress in which you have decided to leave your position? Did you leave, if not, why did you stay?

A majority of respondents chose not to answer the question 2, which asked to describe an occurrence of moral distress in which you have decided to leave your position; they instead referred to their responses from Qualitative Question 1. However, brief responses were submitted for the questions which asked, “Did you leave, if not, why did you stay”? Responses from the participants’ revealed feelings of powerlessness due to morally distressing interactions with physicians, nurse leaders, fellow peers, and patients and families, yet the majority chose to stay in that position albeit for different reasons. The data suggested that a good co-worker and peer relationship helped retention rates for morally distressed nurses considering leaving their position. About half of the nurses that chose to stay wrote, “I stay for my co-workers.” The other half appear to stay in their current position out of necessity and convenience. The responses included staying because it is, “Close to home”, “Staying for scheduling reasons”, “Grass is not greener on the other side”, “Good benefits-401K, Pension”, “Only Level 1 trauma facility in the region”, and several “I’m too old to be hired somewhere else”.

Interestingly, it appeared that nurses who chose to leave the position left “when their disrespect threshold was met” due to unresolved work place lateral violence, patient safety/staffing concerns, and licensure safety concerns. Data suggested that respondents did attempt remediation before departure. The participants shared their concerns were

communicated to their nursing leaders; however, an acceptable resolution was not established.

Addressing Rigor and Trust

Rigor and trustworthiness were addressed in the context of the FACTS mnemonic developed by El Hussein, Jakubec, and Osuji (2015). Fittingness or transferability (F), was addressed by demonstrating that the findings have meaning to others in similar situations. Moral distress qualitative research was examined along with descriptions of the shared experiences of moral distress from bedside acute care critical care nurses... Auditability (A) was addressed by creating an audit trail which includes all research questions, study tools, notes, and excel spreadsheets created by the primary investigator so that subsequent researchers are equipped to repeat the study. Credibility (C) was addressed starting with the data collection process. Qualitative data submissions were extracted from the Qualtrics survey and placed in a secure Microsoft Excel Spreadsheet. Data emersion then took place to gain a deeper understanding of the subject matter, organize the data, and develop themes. Theme development helped fully identify and gain a rich understanding of individual and collective nurse experiences of moral distress which anchored the study. Trustworthiness (T) was addressed through careful attention to fittingness and credibility as described previously to support data confidence, and saturation (S) confidence was established through the process of reading and rereading participant responses until redundancy was noted. Verbatim participants' responses are provided in the analysis and accurately reflect collective impressions and understanding.

In review the analyses indicated that moral distress and hospital ethical climate have a direct effect on a nurses' intent to leave their position and profession, but the effect of moral distress on intent to leave was not moderated by hospital ethical climate. Also, moral distress and perceived leadership integrity had an effect on a nurses' intent to leave their position and the profession but the effect of moral distress on intent to leave was not moderated by perceived leadership integrity.

The primary theme identified from the qualitative data that evoked moral distress in the participants was powerlessness. Powerlessness and its five cluster themes of frustration, inadequacy, mistrust, vulnerability, and disrespect came from five sources: end-of-life situations, physicians, peers, nurse leaders, and patient families. It was not uncommon for nurses to experience moral distress from greater than two sources at one time as demonstrated from shared experiences. These responses add intensity and strength to the quantitative findings associated with this study particularly the importance of a good hospital ethical climate to promote retention. Although the majority of the participants chose to stay for various reasons, there were a number of nurses that chose to leave their current position and even the profession due to moral distress.

Discussion

A modified version of Corley's Theory of Moral Distress (2002) formed the basis of this study to determine if the effect of moral distress on intent to turnover was moderated by ethical climate and leader integrity. To date there have been no other studies that combined moral distress, leadership integrity, and hospital ethical climate on the turnover intent in adult critical care nurses. Only two published mixed methods studies (Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014; Sauerland, Marotta,

Peinemann, Berndt, & Robichaux, 2015) were found that utilized Hamric et al.'s MDS-R. The studies, from the same authors, address adult critical care nurses and pediatric and neonatal nurses respectively.

Similar to previous studies (Corley et al., 2005; Hamric & Blackhall, 2007; Hamric et al., 2012; Pauly et al., 2009), this study supports that there is a negative correlation, or an inverse relationship, between moral distress levels and healthier ethical climates. When the ethical climate is poorer there is a higher level of moral distress. When the ethical climate is healthier nurses' moral distress levels seem to be lower.

This study found correlations between moral distress and problematic end-of-life issues. Findings were consistent with previous studies (Corley et al., 2005; Epstein & Hamric, 2009; Hamric & Blackhall, 2007; Hamric et al., 2012) regarding moral distress related to end-of-life issues such as aggressive and futile treatment. The participants shared over fifty stories describing how they provided futile patient care. Several shared stories of how patients were literally 'rotting in the bed', yet, families and physicians refused to withdraw life support measures, one of which included CPR that caused rib fractures in elderly patients.

Moral distress (MD) as measured in this study had two components, frequency and intensity. The current study indicated a high level (intensity) of moral distress (M= 3.68, SD = 0.76) with low frequency (M = 2.67, SD = 0.65), indicating when moral distress occurred the nurses were intensely affected. Somewhat differently, Sauerland's et al. (2014) study of critical care nurses, reported only moderate level intensity scores, 3.09 (SD, 2.21) to 2.14 (SD, 2.42) and low frequency scores 2.86 (SD, 1.88) to 0.23 (SD, .093). The Sauerland et al. (2015) study of critical care nurses also evaluated ethical

climate. It found a moderate ethical climate 94.39 (SD, 18.3) which is similar to this study's findings (M = 84.7, SD, 15.1). No additional research studies could be located that evaluated the perceived leadership integrity using the PLIS as a predicator of turnover intent. In this study the PLIS mean score indicated a moderate perception of leadership integrity (M = 53.5, SD, 23.1).

The moderating effects of ethical climate and leader integrity on turnover intent was not found to be statistically significant; however, there were significant findings. Both moral distress and leadership integrity had a direct effect on intent to leave position and both moral distress and hospital ethical climate had a direct effect on intent to leave profession. Results from this study suggest that ethical climate and leadership integrity play individual roles that contribute to the creation of a healthy work environment. Healthy work environments have been shown to reduce moral distress and nurse turnover rates.

This study supported intent to leave the position due to moral distress. The findings supported previous studies (DeTienne, Agle, Phillips, & Ingerson, 2012; Dodek, Wong, Norena, Ayas, Reynolds, Keenan, & Alden, 2016; Pauly, Varcoe, Storch, & Newton, 2009; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015) and the AACN's Health Work Environment survey which found nurse stated an intent to leave their position and the profession due to moral distress and unhealthy work environments.

Finally, this as with previous studies (Oh & Gastmans, 2015; Redman & Fry, 2000; Sauerland et al., 2014; Shorideh, Ashktorab, & Yaghmaei, 2012) findings supported the qualitative themes that identified institutional constraints, communication

problems, futile actions, physician obstinacy, bullying, and lateral violence as sources of moral distress.

Strengths and Limitations

Overall this is a rich study that contributes to nursing knowledge related to moral distress. The study fills a gap in the literature by not only looking at moral distress generated from clinical situations but by examining the influence of ethical climate and leader integrity perspectives. The mixed method design is also a strength of this study and as previously reported, there are only two other mixed methods studies published that examined levels of moral distress in relation to ethical climate.

The study's respondents are members of AACN, a professional nursing organization which promotes commitment to nursing excellence. Also, because of the AACN support, the survey was distributed nationwide. Nurses from across the United States had an opportunity to participate so the results are not limited to a particular area or region.

The study findings are limited to adult critical care nurses and, thus, will not be generalizable to nurses' working in other arenas. Only AACN members, with a current reported membership of 100,000, were eligible to take part in this study. According to the U.S. Department of Health and Human Services, The Registered Nurse Population study (2008), there were over 318,000 critical care nurses working in acute care environments. Therefore, this study may not reflect the views and experiences of all critical care nurses.

Participants may have chosen not to complete the survey because of discomfort related to the memories of traumatic experiences. Likewise, those who have very little experience with, or limited recognition of, ethically charged situations might choose not

to participate thinking they have little to contribute. Additionally, participants may have answered the surveys wanting to provide the "right response" and fallen victim to response bias, in particular social response bias where the nurse would over-report moral distress, while others may under-report moral distress to make them look more favorable.

Instrument burden on respondents could potentially affect the response rate. The demographic survey and 4 research tool may have been considered too burdensome to complete and therefore limit submitted responses.

Future Recommendations

Nurse retention in adult critical care areas requires further research to investigate the effects of moral distress, leadership integrity, and ethical climates on turnover intent. The national nursing shortage reinforces the need to study work environments and develop solutions that foster healthy work environments. Exploration of these variables in other specialty areas will help identify the extent to which moral distress occurs outside the realm of adult critical care. Studies from larger samples of critical care nurses, would allow for greater generalization. Critical care nurses are not required to be members of AACN and therefore it would be beneficial to perform a study inclusive of all critical care nurses. Continued study on demographics (e.g. geographical location, for-profit versus not-for-profit, magnet versus non-magnet, urban versus rural) is needed to find if additional contributing factors emerge.

Education is another key component. Moral distress education should be added to all acute care critical care nurse curricula to ensure appropriate knowledge transfer takes place. Moral distress education should also be added to leadership development training for healthcare administrators and nurse leaders. The qualitative data from this study

provides real life case studies that demonstrate how leaders can propagate or neutralize moral distress within their organizations.

Finally, the utilization and support by leadership of AACN's "The 4A's to Rise Above Moral Distress" and Healthy Work Environment (HWE) initiatives in the critical care environment should be revisited. Nationwide studies inclusive of all critical care nurse, could measure moral distress levels pre and post HWE initiation, and study how the leaders' integrity contribute to the health of the work environment.

Conclusions

Moral distress is a painful psychological imbalance that negatively affects nurses' health, satisfaction, and retention. With the backdrop of the nursing shortage, nurse leaders must find ways to maintain a nursing workforce that is committed to staying in their organizations. To date, nursing research has focused primarily on clinical situations that give rise to moral distress. However, more studies exploring specifically how nurse leaders' and the work environment influence the development of moral distress and subsequent intent to turnover in nursing are needed. Healthcare leaders, particularly nurse leaders, must recognize moral distress, create healthy work environments, and demonstrate ethical leadership to retain their nurse workforce.

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Chapter 4

Summary and Conclusion

To date, nursing research has focused primarily on clinical situations that give rise to moral distress. This study examined the influence of leadership and ethical climate on moral distress and subsequent intent to turnover thereby increasing and broadening the body of knowledge on the topic. A qualitative component explored the perspectives of nurses that self-identified as having experienced moral distress in the professional work environment. By combining both quantitative and qualitative data, a richer depth of understanding was gained as there are a shortage of mixed methods studies on moral distress. Sauerland et al. (2014) is the only other mixed method study in the literature that has conducted moral distress research using the MDS-R on adult critical care nurses.

Overall, the moderating effects of ethical climate and leader integrity on turnover intent was not statistically significant; however, there were significant findings. Both moral distress and leadership integrity have a direct effect on intent to leave position and both moral distress and hospital ethical climate have a direct effect on intent to leave position. These findings give credence as to why nurse leaders should incorporate AACN (2004) Health work Environment interventions to help combat moral distress and nurse turnover.

Interestingly, low moral distress frequency can be quiet and deceptive from a quantitative standpoint; therefore, nurse leaders should not equate low occurrence with intensity. These are two separate measures. The added qualitative component revealed the depths of pain and disempowerment nurses felt when moral distress was encountered. The words of the nurse respondents supported the premise that moral distress is not

always quantifiable. Sometimes one bad experience is enough for a nurse to make the decision to leave a position, or worse, the profession. Additional qualitative research on moral distress is needed to complement existing data to build a comprehensive picture of the devastating effects on the nursing profession.

Moral distress is a painful psychological imbalance that negatively affects nurses' health, satisfaction, and retention. With the backdrop of the nursing shortage, nurse leaders must find ways to maintain a nurse workforce that is committed to staying in their organizations. Healthcare leaders, particularly nurse leaders, must minimize situations leading to moral distress and create healthy work environments to retain nurses. To date, nursing research has focused primarily on clinical situations that give rise to moral distress and very few studies have explored specifically how nurse leaders' and the work environment influences the development of moral distress. Additional research is needed to explore leader and environmental induced moral distress on subsequent intent to turnover in nursing.

Finally, although ICU nurses have little control over difficult situations in their work environment such as end-of-life, dealing with difficult physicians, peers, patients, patient family members, and nurse leaders, finding indicate these challenges can be decreased with a good hospital ethical climate such as is encompassed in the AACN's 2004 Healthy Work Environment (HWE) initiative. Future studies are recommended to explore if making the Healthy Work Environment initiative a standard across all critical care work environments will decrease moral distress and turnover intent. Perhaps the standardization of the HWE will prevent nurses from leaving the bedside as predicated and decrease the projected nursing shortage.

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Appendix A. IRB Approval Letter

THE UNIVERSITY OF TEXAS AT TYLER
3900 University Blvd. • Tyler, TX 75799 • 903.565.5774 • FAX: 903.565.5858

Office of Research and Technology Transfer

Institutional Review Board

November 6, 2015

Dear Ms. Makiya,

Your request to conduct the study: *Moral Distress, Leadership Integrity, Ethical Climate and Turnover Intent in Critical-Care Nurses,* IRB #F2015-18 has been approved by The University of Texas at Tyler Institutional Review Board as a study exempt from further IRB review. This approval includes a waiver of signed, written informed consent. In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the IRB office (G. Duke).

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

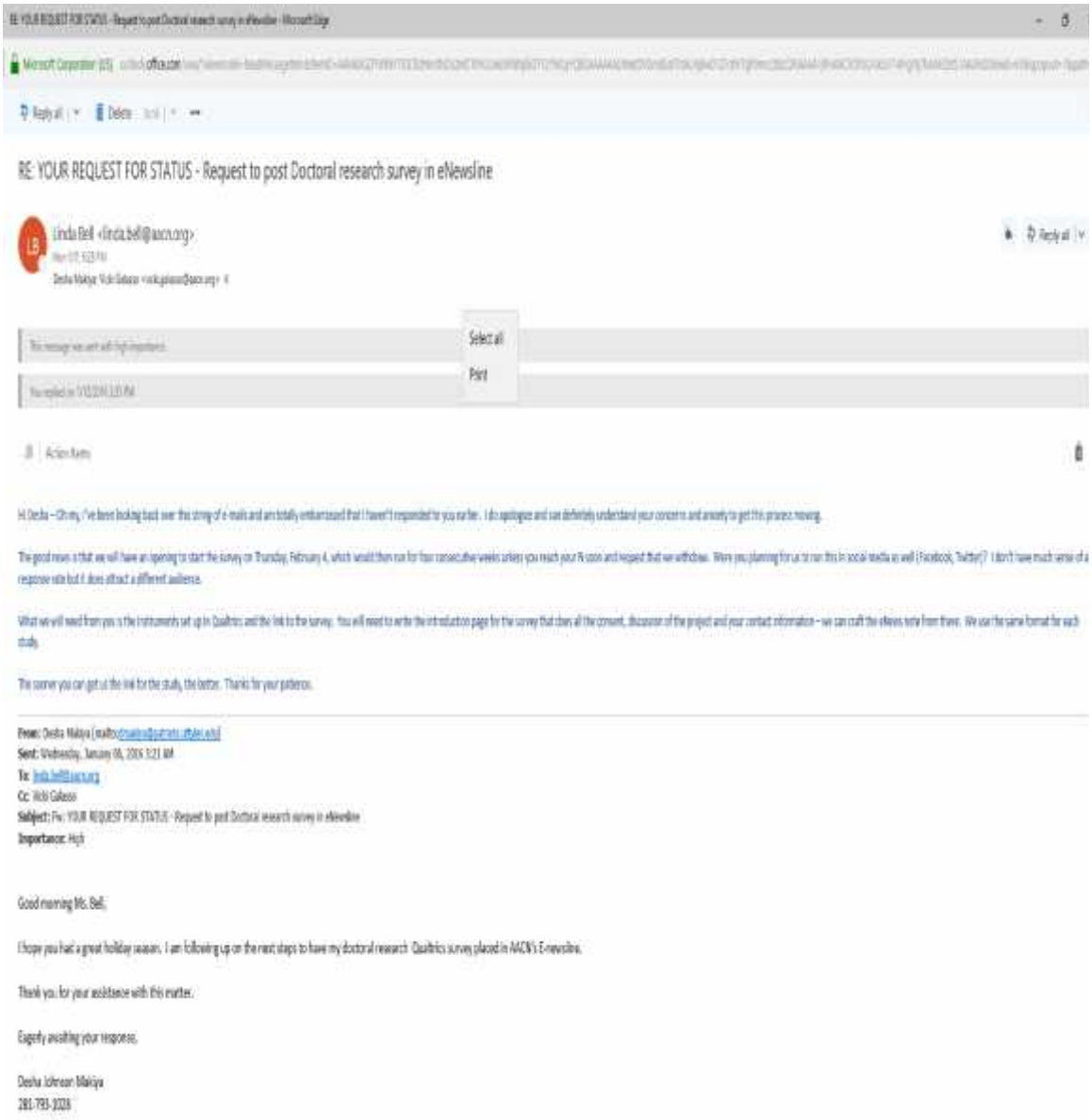
- Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity
- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.
- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.

Best of luck in your research, and do not hesitate to contact me if you need any further assistance.

Sincerely,

Gloria Duke, PhD, RN
Chair, UT Tyler IRB

Appendix B. AACN Approval



RE: YOUR REQUEST FOR STATUS - Request to post Doctoral research survey in eNewsline

Linda Bell <lindu.bell@aacn.org>

Reply all

Select all

Print

Hi Deeba – Oh my, I've been looking back over this string of e-mails and am totally embarrassed that I haven't responded to you earlier. I do apologize and can definitely understand your concern to and anxiety to get this process moving.

The good news is that we will have an opening to start the survey on Thursday, February 4, which would then run for four consecutive weeks unless you reach your N soon and request that we withdraw. Were you planning for us to run this in social media as well (Facebook, Twitter)? I don't have much sense of a response rate but it does attract a different audience.

What we will need from you is the instruments set up in Qualtrics and the link to the survey. You will need to write the introduction page for the survey that does all the consent, discussion of the project and your contact information – we can craft the eNews note from there. We use the same format for each study.

The sooner you can get us the link for the study, the better. Thanks for your patience.

From: Deeba Makiya [mailto:
Sent: Wednesday, January 06, 2016 9:21 AM
To:
Cc: Rob Galasso
Subject: FW: YOUR REQUEST FOR STATUS - Request to post Doctoral research survey in eNewsline
Importance: High

Good morning Ms. Bell,

I hope you had a great holiday season. I am following up on the next steps to have my doctoral research Qualtrics survey placed in AACN's E-newsline.

Thank you for your assistance with this matter.

Eagerly awaiting your response.

Deeba Johnson Makiya
281-793-3028

Appendix C. eNewsline Post

AACN CriticalCare eNewsline
American Association of Critical-Care Nurses

Action | Evidence | News | Resources | AACN Update | Bookstore | Career

View Web Version

Connect with AACN

February 4, 2016

EVIDENCE - Antiplatelet therapy for ACS
NEWS - National Wear Red Day, Feb. 5
RESOURCE - Nutrition for critically ill patients
AACN UPDATE - NEW: Apply for NTI scholarship by Feb. 29

"The longer I'm in the profession, the more experiences shape my life, the more amazing colleagues influence me, the more I see the micro and macro power of nursing." ~ **Joni Watson**

Action | Evidence | News | Resources | AACN Update | Bookstore | Career Top

Comment on draft pain management scope and standards

The American Society for Pain Management Nursing, Lenexa, Kansas, requests your feedback on the draft version of "Pain Management Nursing: Scope and Standards of Practice," 2nd ed. The comment period is open through Feb. 18.

Participate in study on LVADs

Maureen Flattery and Katherine Rodman, Virginia Commonwealth University Health System, Richmond, and Peggy Kirkwood, Mission Hospital, Mission Viejo, California, invite critical care nurses to participate in a study to determine the frequency of continuous flow left ventricular assist device (CF-LVAD) patient admissions to non-VAD hospitals and how providers achieve and maintain competency in the care of patients with CF-LVAD. The confidential survey takes about 10 to 15 minutes. Please email Flattery or email Kirkwood with your questions, or call 804-828-4571.

Participate in survey on moral distress

Desha Johnson Makiya, a doctoral nursing student at The University of Texas at Tyler, invites critical care nurses to participate in the study "Moral Distress, Leadership Integrity, Ethical Climate, and Turnover Intent in Critical-Care Nurses." The confidential survey takes about 20 to 30 minutes. After completing the survey, you have the option to enter a drawing for the chance to win an iPad Mini 2 or a Kindle Fire. Please email Johnson Makiya with your questions, or call 281-793-1028.

Appendix D. Letter of Invitation and Informed Consent

Online Survey Consent Form

You are being invited to participate in an online survey as part of a research study titled Moral Distress, Leadership Integrity, Ethical Climate, and Turnover Intent in Critical-Care Nurses. This study is being done by Desha Johnson Makiya, a PhD in Nursing student from The University of Texas at Tyler. You were selected to participate in this study because you are a member of the American Association of Critical Care Nurses. Critical care nurse members working in adult critical care settings are asked to participate.

The purpose of this study is to explore relationships between the levels of moral distress experienced by critical nurses and the likelihood of a nurse leaving a position as well as the perspectives of nurses that self-identify as having experienced moral distress in the professional work environment. If you agree to take part in this study, you will be asked to complete an online survey, which takes approximately 20-30 minutes to complete.

Your survey answers will be stored in Qualtrics, a web-based survey software platform. No identifying information such as your name, email address, or IP address will be requested or collected. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. After your survey is completed you have the option of entering your name with email address into a drawing for a chance to win an iPad Mini 2 or a Kindle Fire. Two iPad minis and two Kindle Fires will be given away. Your name and email address information will be maintained separately from survey responses.

You may not directly benefit from this research; however, we hope that your participation in the study may assist in advancing nursing research on this topic.

We believe there are no known risks associated with this research study; however, you may become slightly distressed when discussing situations that cause you moral distress at your workplace. If you become distressed you may quit the surveys at any time you wish.

I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided. Information may be shared with:

- Organizations giving money to support this study

- Other researchers interested in putting together your information with information from other studies
- Information shared through presentations or publications

I understand The University of Texas at Tyler Institutional Review Board (the group that oversees research conducted at the University) may look at the research documents. These documents will not have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

Your participation in this study is completely voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. If you have questions about this project or if you have a research-related problem, you may contact the researcher Desha Johnson Makiya, at dmakiya@patriots.uttyler.edu or (281) 793-1028 or dissertation committee chair, Dr. Susan Yarbrough, PhD, RN, CNE at syarbrough@uttyler.edu or (903) 565-5554.

If you have any questions concerning your rights as a research subject, you may contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttlyer.edu or the University's Office of Sponsored Research:

The University of Texas at Tyler

c/o Office of Sponsored Research

3900 University Blvd

Tyler, TX 75799

If you have read and understood this consent form and agree to participate in this research study, continue to the next step to determine if you meet the inclusion criteria. Consent is implied when you click on the Qualtrics survey link.

Appendix E. Moral Distress Scale-Revised Permission Letter

From: Ann B Hamric <abhamric@vcu.edu>
Sent: Wednesday, June 17, 2015 6:38 AM
To: Desha Makiya
Cc: Alison Crehore
Subject: Re: Permission to use Moral Distress Scale-Revised

Dear Ms. Mikaya,

Thank you for your interest in the Moral Distress Scale – Revised (MDS-R). There are six versions of this scale: nurse, physician and other healthcare professional versions for adult settings (including ICUs and other inpatient units), and parallel versions for healthcare providers in pediatric settings. The MDS-R shows evidence of reliability and validity, and a publication describing the instrument and its testing has been published in the *American Journal of Bioethics: Primary Research:*

> Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research, 3*(2), pp. 1-9.

You should read this article before deciding whether the MDS-R will be appropriate for your project.

The MDS-R has a unique scoring scheme, designed to give a measure of current level of moral distress. Conceptually, items that have never been experienced or are not seen as distressing do not contribute to an individual's level of moral distress. As noted, the Likert scales for each item have been adjusted to 0-4 from Corley's original 1-7 scoring range. To generate a composite score, the frequency score and intensity (named "level of disturbance") score for each item should be multiplied; note that this results in eliminating items never experienced or not distressing from the composite score. In addition, items rarely experienced or minimally distressing have low scores and items experienced frequently and as most distressing have higher scores. Each item product of frequency and intensity will range from 0 to 16. To obtain a composite score of moral distress, these individual item products should be added together. Using this scoring scheme allows all items marked as never experienced or not distressing to be eliminated from the score, giving a more accurate reflection of actual moral distress. The resulting score based on 21 items will have a range of 0 – 336.

I am happy to grant permission to use any of the MDS-R scales, but require agreement to the following condition: **Individuals wishing to use the MDS-R must agree to share their data with Drs. Hamric and Corley in an SPSS file in order to further the psychometric testing of the instrument.**

If you agree to adhere to this condition for use, I am happy to give you permission to use the scales. You do not need permission from Dr. Corley, as this is a new instrument. I have attached the adult nurse

version of the MDS-R; let me know if you are interested in other versions of the instrument. If you decide to change items for particular specialty purposes or for different settings or outside the USA, Dr. Corley and I request that you keep us informed of the changes you make and the results you obtain.

Best wishes for success with your research!

Ann Hamric

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Appendix F. Hospital Ethical Climate Survey Permission Letter

June 15, 2015

Dosha Maidya
Doctoral student
University of Texas at Tyler
Tyler, Texas

Dear Dosha:

You have my permission to use the Hospital Ethical Climate Survey (HECS) in your study of the Relationship between Moral Distress, Ethical Climate, Perceived Leadership Behavioral Integrity and the Turnover Intent in Critical Care Nurses. Thank you for your interest in the HECS.

Sincerely,

Linda L. Olson, PHD, RN

Linda L. Olson, PhD, RN,NEA-BC

Appendix G. Perceived Leader Integrity Scale Permission Letter

Terms of Use

Consistent with its original mission as a tool to stimulate and facilitate scientific research on destructive leadership, the PLIS may be freely used for noncommercial research purposes. License fees for commercial applications are negotiated on a case-by-case basis.

To use the PLIS in your research or leadership development work, please contact S. Bartholomew Craig, Ph.D. (bart_craig@ncsu.edu).

Appendix H. Demographics

1) Is your current position primarily that of a staff nurse in an

- ☐ Coronary Care Unit
- ☐ Cardiovascular Intensive Care Unit
- ☐ Medical Intensive Care Unit
- ☐ Surgical Intensive Care
- ☐ Shock Trauma Intensive Care
- ☐ Neurological Intensive Care
- ☐ Burn Intensive Care Unit

2) What is your gender?

- ☐ Male
- ☐ Female

3) What is your basic nursing education?

- ☐ Diploma in Nursing
- ☐ Associate Degree in Nursing
- ☐ Bachelor of Science in Nursing
- ☐ Other

4) Is your hospital/facility

- ☐ Magnet
- ☐ Non-Magnet

5) Total number of years working as a critical care nurse._____ years

6) Total number of years working as a registered nurse _____years

7) How long have you been employed at your current hospital? _____ years

8) What is your age? _____years

9) What is your current employment status?

- ☐ Full-time
- ☐ Part-time
- ☐ Supplemental/PRN

10) What is your racial or ethnic background? (choose only one)

- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Hispanic
- ☐ American-Indian or Alaskan

11) Which of the following statements best describes your basic education on healthcare ethics?

- ☐ Ethics content integrated throughout program of study
- ☐ Ethics course
- ☐ No ethics content or course work
- ☐ Cannot recall

12) Have you taken any continuing education courses in healthcare ethics?

- ☐ Yes
- ☐ No

13) Does your organization have an ethics committee?

- ☐ Yes
- ☐ No

14) Have you requested or participated in a consultation with the ethics committee?

- ☐ Yes
- ☐ No

Appendix I. Moral Distress-Revised Scale

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* and *Level of Disturbance*.

	Frequency					Level of Disturbance				
	Never				Very frequently	None				Great extent
	0	1	2	3	4	0	1	2	3	4
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.										
2. Witness healthcare providers giving "false hope" to a patient or family.										
3. Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.										
4. Initiate extensive life-saving actions when I think they only prolong death.										
5. Follow the family's request not to discuss death with a dying patient who asks about dying.										
6. Carry out the physician's orders for what I consider to be unnecessary tests and treatments.										
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										
9. Assist a physician who, in my opinion, is providing incompetent care.										
10. Be required to care for patients I don't feel qualified to care for.										
11. Witness medical students perform painful procedures on patients solely to increase their skill.										

	Frequency	Level of Disturbance

	Never				Very frequently	None				Great extent
	0	1	2	3	4	0	1	2	3	4
12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
16. Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.										
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										
18. Witness diminished patient care quality due to poor team communication.										
19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
20. Watch patient care suffer because of a lack of provider continuity.										
21. Work with levels of nurse or other care provider staffing that I consider unsafe.										
If there are other situations in which you have felt moral distress, please write them and score them here:										

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I've never considered quitting or left a position _____
Yes, I considered quitting but did not leave _____
Yes, I left a position _____

Are you considering leaving your position now? Yes No

Appendix J. Hospital Ethical Climate Survey

	Almost Never True	Seldom	Sometimes	Often	Almost Always True
1 My peers listen to my concerns about patient care.	1	2	3	4	5
2 Patients know what to expect from their care.	1	2	3	4	5
3 When I'm unable to decide what's right or wrong in a patient care situation, my manager helps me.	1	2	3	4	5
4 Hospital policies help me with difficult patient care issues/problems.	1	2	3	4	5
5 Nurses and physicians trust one another.	1	2	3	4	5
6 Nurses have access to the information necessary to solve a patient care issue.	1	2	3	4	5
7 My manager supports me in my decisions about patient care.	1	2	3	4	5
8 A clear sense of the hospital's mission is shared with nurses.	1	2	3	4	5
9 Physicians ask nurses for their opinions about treatment decisions.	1	2	3	4	5
10 My peers help me with difficult patient care issues/problems.	1	2	3	4	5
11 Nurses use the information necessary to solve a patient care issue/problem.	1	2	3	4	5
12 My manager listens to me talk about patient care issues/problems.	1	2	3	4	5

13 The feelings and values of all parties involved in a patient care issue/problem are taken into account when choosing a course of action.	1	2	3	4	5
14 I participate in treatment decisions for my patients.	1	2	3	4	5
15 My manager is someone I can trust.	1	2	3	4	5
16 Conflict is openly dealt with, not avoided.	1	2	3	4	5

	Almost Never True	Seldom	Sometimes	Often	Almost Always True
17 Nurses and physicians here respect each other's opinions even when they disagree about what is best for the patient.	1	2	3	4	5
18 I work with competent colleagues.	1	2	3	4	5
19 The patient's wishes are respected.	1	2	3	4	5
20 When my peers are unable to decide what's right or wrong in a particular patient care situation, I have observed that my manager helps them.	1	2	3	4	5
21 There is a sense of questioning, learning, and seeking creative responses to patient care problems.	1	2	3	4	5

22 Nurses and physicians respect one another.	1	2	3	4	5
23 Safe patient care is given on my unit.	1	2	3	4	5
24 My manager is someone I respect.	1	2	3	4	5
25 I am able to practice nursing on my unit as I believe it should be practiced.	1	2	3	4	5
26 Nurses are supported and respected in this hospital.	1	2	3	4	5
27 Nurses freely admit their mistakes.	1	2	3	4	5
28 Nurses feel free to report mistakes others make.	1	2	3	4	5

Appendix K. Perceived Leader Integrity Scale

Instructions: The following items concern your perceptions of another person's behavior. Select responses to indicate how well each item describes the person you are rating.
1 = Not at all 2 = Barely 3 = Somewhat 4 = Well

	Not at All	Barely	Somewhat	Well
1. Puts his or her personal interests ahead of the organization	1	2	3	4
2. Would risk other people to protect himself or herself in work matters	1	2	3	4
3. Enjoys turning down requests	1	2	3	4
4. Deliberately fuels conflict between other people	1	2	3	4
5. Would blackmail an employee if she or he thought she or he could get away with it	1	2	3	4
6. Would deliberately exaggerate people's mistakes to make them look bad to others	1	2	3	4
7. Would treat some people better if they were of the other sex or belonged to a different ethnic group	1	2	3	4
8. Ridicules people for their mistakes	1	2	3	4
9. Can be trusted with confidential information	1	2	3	4
10. Would lie to me	1	2	3	4
11. Is evil	1	2	3	4

12. Is not interested in tasks that don't bring personal glory or recognition	1	2	3	4
13. Would do things that violate organizational policy and then expect others to cover for him or her	1	2	3	4
14. Would allow someone else to be blamed for his or her mistake	1	2	3	4
15. Would deliberately avoid responding to e-mail, telephone or other messages to cause problems for someone else	1	2	3	4
16. Would make trouble for someone who got on his or her bad side	1	2	3	4
17. Would engage in sabotage against the organization	1	2	3	4
18. Would deliberately distort what other people say	1	2	3	4
19. Is a hypocrite	1	2	3	4
20. Is vindictive	1	2	3	4
21. Would try to take credit for other people's ideas	1	2	3	4
22. Likes to bend the rules	1	2	3	4
23. Would withhold information or constructive feedback because he or she wants someone to fail	1	2	3	4
24. Would spread rumors or gossip to try to hurt people or the organization	1	2	3	4
25. Is rude or uncivil to coworkers	1	2	3	4

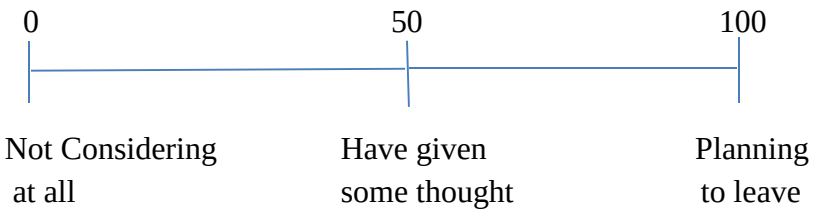
26. Would try to hurt someone's career because of a grudge	1	2	3	4
27. Shows unfair favoritism toward some people	1	2	3	4
28. Would steal from the organization	1	2	3	4
29. Would falsify records if it would help his or her work situation	1	2	3	4
30. Has high moral standards	1	2	3	4

Appendix L. Visual Analogue Scale – Intent to Turnover

Move the slider to the place on the scale of 0 to 100 that represents how seriously you are considering leaving your current position.

How likely are you to leave your current position in the next 12 month?

How likely are you to leave the profession within the next 12 months?



Appendix M. Biographical Sketch

NAME Desha Johnson Makiya	POSITION TITLE Doctoral Candidate, The University of Texas at Tyler Visiting Assistant Professor at Sam Houston State University, School of Nursing, The Woodlands, TX Post Anesthesia Recovery Nurse, Memorial
eRA COMMONS USER NAME (credential, e.g., agency login)	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY
Alcorn State University, Alcorn State, MS	BSN	05/99	Nursing
University of Phoenix, Houston, TX	MBA	08/05	Health Administration
University of Texas at Tyler, Tyler, TX	PhD	12/16	Nursing

A. Personal Statement
B. Positions and Honors

Positions and Employment

2016-Present	Visiting Assistant Professor, Sam Houston State University, The Woodlands, TX
2015-Present	Post Anesthesia Recovery Nurse, Memorial Hermann Hospital System, The Woodlands, TX
2007-2015	Education Resource Specialist III, Memorial Hermann Hospital System, Houston, TX
2005-2007	Director of Patient Care, Memorial Hermann Hospital System, Houston, TX
2003-2005	Nurse Manager, DMS Imaging, Houston, TX
2002-2004	ICU Staff Nurse, Methodist Willowbrook Hospital, Houston, TX
2001-2011	Agency ICU Nurse, Staff Search/Crdentia, Houston, TX

2000-2001	ICU Staff Nurse, Central Mississippi Medical Center, Jackson, MS
1999-2001	Staff Nurse, Jackson Memorial St. Dominic Hospital, Jackson, MS

C. Professional Memberships

American Association of Critical Care Nurses – North Harris Montgomery Chapter Historian

American Nurses Association

Graduate Student Nursing Academy

Sigma Theta Tau International, Honor Society of Nursing

Texas Nurses Association

D. Honors

2005 Manager of the Year – Memorial Hermann Health Care System, Houston TX

2013 Good Samaritan Foundation Bronze Award – Houston, TX