

# MORAL DISTRESS OF STAFF NURSES IN A MEDICAL INTENSIVE CARE UNIT

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- **BACKGROUND** Moral distress is caused by situations in which the ethically appropriate course of action is known but cannot be taken. Moral distress is thought to be a serious problem among nurses, particularly those who practice in critical care. It has been associated with job dissatisfaction and loss of nurses from the workplace and the profession.
- **OBJECTIVES** To assess the level of moral distress of nurses in a medical intensive care unit, identify situations that result in high levels of moral distress, explore implications of moral distress, and evaluate associations among moral distress and individual characteristics of nurses.
- **METHODS** A descriptive, questionnaire study was used. A total of 28 nurses working in a medical intensive care unit anonymously completed a 38-item moral distress scale and described implications of experiences of moral distress.
- **RESULTS** Nurses reported a moderate level of moral distress overall. Highest levels of distress were associated with the provision of aggressive care to patients not expected to benefit from that care. Moral distress was significantly correlated with years of nursing experience. Nurses reported that moral distress adversely affected job satisfaction, retention, psychological and physical well-being, self-image, and spirituality. Experience of moral distress also influenced attitudes toward advance directives and participation in blood donation and organ donation.
- **CONCLUSIONS** Critical care nurses commonly encounter situations that are associated with high levels of moral distress. Experiences of moral distress have implications that extend well beyond job satisfaction and retention. Strategies to mitigate moral distress should be developed and tested. (*American Journal of Critical Care*. 2005;14:523-530)

Ethical issues and dilemmas are inherent in nursing practice. An adverse experience termed “moral distress” is thought to be a serious problem of nurses, particularly those who practice in critical care areas. Moral distress has been defined as painful feelings and/or psychological disequilibrium that occurs in situations in which the ethically right course of action is known but cannot be acted upon. As a result, persons in moral distress act in a manner contrary to their personal and professional values.<sup>1</sup> Moral distress differs from moral dilemmas; in moral dilemmas, the ethically correct course of action is in doubt.

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*Moral distress is psychological disequilibrium that occurs when the ethically right course of action is known but cannot be acted upon.*

Moral distress in nursing practice has been named and discussed at least since the 1980s. In that decade, Jameton<sup>2</sup> defined moral distress, and Wilkinson<sup>3</sup> explored the phenomenon to generate a model of the moral distress experience. Of note, intensive care nurses were highly represented in subjects interviewed by Wilkinson in her study. In 1995, Corley<sup>4</sup> developed the Moral Distress Scale (MDS) to measure nurses’ moral distress and to identify moral issues. Corley compiled responses

to the MDS from 111 critical care nurses. Critical care nurses had moderate to severe moral distress. Situations associated with the greatest moral distress for the largest percentage of nurses were those associated with providing aggressive care and prolonging life.

Moral distress can have important consequences, including stress, burnout, job dissatisfaction, and departure from the work environment and/or nursing.<sup>5,6</sup> No data are available on how moral distress might affect the quality of nursing care.

Despite the intensity and frequency of morally distressing encounters by critical care nurses, investigation of nurses' experiences of moral distress has been limited. This lack of attention is of particular concern because of the impact of moral distress on retention and the widening disparity between workforce needs in critical care nursing and the availability of nurses. In 2004, the American Association of Critical-Care Nurses issued a position statement on moral distress.<sup>1</sup> The association charged every nurse and every employer with responsibility for implementing programs to address and mitigate harmful effects of moral distress.

*AACN has charged every nurse and employer to address and mitigate harmful effects of moral distress.*

Our own observations and interactions with members of the nursing staff of a critical care unit at Rush University Medical Center, Chicago, Ill, suggested that staff nurses were experiencing considerable moral distress. Further, informal interviews with staff nurses suggested that adverse consequences of experiences of moral distress extended beyond consequences related to job satisfaction and retention. Hence we did an exploratory, descriptive study with the following aims:

- assess the level of moral distress among nurses working in a medical intensive care unit (MICU),
- identify situations associated with significant moral distress,
- explore implications of morally distressing experiences, and
- evaluate possible associations among demographic characteristics of respondents and level of moral distress.

We considered this exploration a necessary prelude to proposal of strategies to manage moral distress and to subsequent evaluation of implemented strategies.

## Methods

An exploratory, descriptive, nonexperimental questionnaire study was conducted. The study proposal was

reviewed by the medical center's office of research affairs. Informed consent was not required, and the study was exempted from review by the institutional review board because of the anonymity and voluntary participation of the respondents.

The study was done during a 6-week period in January and February 2005. Potential respondents were identified from the roster of staff nurses assigned to the MICU at the medical center. Letters introducing the study and the requirements of participation were distributed to staff nurses along with printed questionnaires. Nurses were asked to participate by completing the questionnaires anonymously and returning completed forms in sealed envelopes to a locked drop box placed in the unit.

## Instrument

A 2-part questionnaire was used to collect data. Part 1 consisted of Corley's MDS designed to measure nurses' experiences of moral distress in 38 clinical situations. Respondents were asked to indicate on a 7-point Likert scale (from 0=none to 7=a great extent) the level of moral distress they experienced in each clinical situation and how frequently (0=never to 7=very often) they encountered the situation. Reliability and validity have been established for the MDS.<sup>6</sup> Part 2 of the questionnaire was open ended and asked respondents to address the following:

If you are comfortable doing so, please indicate in the space provided below how experiences of moral distress have affected you. For example, some nurses have identified moral distress as influencing job satisfaction or changes in religious practices. Any information you can provide on the impact of moral distress—on attitudes, behaviors, beliefs, or anything you think pertinent—is welcome.

## Data Analysis

Means were computed from intensity and frequency ratings for each item on the MDS. An item score was computed for each of the 38 items. Each item score was calculated by multiplying the mean of the moral distress intensity (MDI) ratings by the mean of the moral distress frequency (MDF) ratings for that item. The range of possible item scores was 0 to 36. A moral distress score was calculated for each respondent by summing the respondent's item scores. The range of possible values for the moral distress scores was 0 to 1368. Free-text responses describing implications of experiences of moral distress were analyzed independently by 3 evaluators to detect common themes.

**Table 1** Demographic characteristics of the respondents

Characteristic	% of respondents
Age, years	
20-30	40
31-40	24
41-50	28
51-60	8
Educational preparation	
Associate degree/diploma	8
Baccalaureate	92
Experience in critical care nursing, years	
0-2	32
3-5	36
6-10	8
11-20	20
21-30	4
Sex	
Male	15
Female	77
No response	8

Data were analyzed by using SPSS software (SPSS, Inc, Chicago, Ill). Correlations between moral distress scores and years of nursing experience were calculated by using the Pearson product moment correlation. Associations between moral distress and age, years of experience in critical care, education, and sex were calculated by using the Kruskal-Wallis nonparametric test. A *P* value of less than .05 was considered significant.

## Results

Of the 39 questionnaires distributed, 28 (72%) were returned. One questionnaire was incomplete and was excluded from analysis. Demographic characteristics of subjects are given in Table 1. Respondents were predominately women, were educated at the baccalaureate level, and had a mean of 9.24 years of nursing experience.

The mean MDI rating for all respondents for all items was 3.66 (range 1.76-5.79; SD 1.73), indicating a moderate intensity of moral distress overall. The mean MDF score was 1.73 (range 0.74-4.42; SD 0.90), indicating that, overall, situations associated with moral distress did not occur frequently.

Item scores revealed situations most associated with moral distress. Items with item scores of 15 or greater (possible range 0-36) and MDI and MDF scores for each item are italicized and boldfaced in Table 2. MDI scores for these situations were all greater than 4; MDF scores ranged from 3.26 to 4.63. Items related to provision of aggressive care thought not to be in a patient's best interest were the source of the greatest

distress and were associated with the highest intensity and frequency of moral distress.

Demographic variables analyzed in relation to moral distress scores were age, sex, educational preparation, years of nursing experience, and years of critical care experience. The years of experience in nursing were positively correlated with moral distress scores ( $r = .0476$ ;  $P = .02$ ). No other significant associations were found.

Respondents were asked to describe the personal impact of morally distressing situations. Of the 28 respondents, 20 provided descriptions. Although the length of responses ranged from a few sentences to a full page of text, every nurse who responded was able to describe some detrimental effect of moral distress. These included the following representative examples:

### Job Satisfaction/Retention

I often equate my job with "keeping dead people alive." On these days, I dread coming to work. (respondent 14)

[S]ometimes I feel I should just go work in a doctor's office. (respondent 1)

I have thought of leaving the MICU because of the sad and depressive state our patients are in. (respondent 4)

I have definitely thought of leaving the nursing profession and oftentimes the MICU. (respondent 5)

I have changed my RN role in the past due in large part to experiences of distress . . . and I could change my role again if I needed to. (respondent 11)

I know this is a job I won't do forever. I've cut down my hours already. (respondent 22)

*"I often equate my job with 'keeping dead people alive.' On these days, I dread coming to work."*

### Actions/Attitudes Toward Patients

There are certain patient assignments that become unbearable for more than a couple of days—we share these patients among the unit staff. (respondent 2)

**Table 2** Moral Distress Scale items associated with highest levels of moral distress

Item	Moral distress rating		Item score
	Intensity	Frequency	
<i>Continue to participate in care for hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to "pull the plug"</i>	5.57	4.63	25.79
<i>Follow a family's wishes to continue life support even though it is not in the best interest of the patient</i>	5.41	4.59	24.83
<i>Initiate extensive life-saving actions when I think it only prolongs death</i>	5.44	4.15	22.58
<i>Follow the family's wishes for the patient's care when I do not agree with them but do so because the hospital administration fears a lawsuit</i>	4.75	3.67	17.43
<i>Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients</i>	4.81	3.37	16.21
<i>Provide care that does not relieve the patient's suffering because the physician fears increasing doses of pain medication will cause death</i>	4.93	3.26	16.07
Carry out physician's order for unnecessary tests and treatments	4.00	3.07	12.28
Follow orders for pain medication even when the medications prescribed do not control the pain	4.15	2.81	11.66
Work with physicians who are not as competent as patient care requires	5.15	2.15	11.07
Prepare an elderly man for surgery to have a gastrostomy tube put in who is severely demented and a "no code"	4.07	2.67	10.87
Assist a physician who, in your opinion, is providing incompetent care	5.00	1.96	9.80
Work with nurses who are not as competent as patient care requires	4.63	1.78	8.24
Work with levels of nurse staffing that I consider "unsafe"	3.93	1.67	6.56
Work with nursing assistants who are not as competent as patient care requires	3.74	1.74	6.51
Observe without taking action when health care personnel do not respect the patient's privacy	3.46	1.77	6.12
Follow a family's request not to discuss death with a dying patient who asks about dying	3.78	1.59	6.01
Let medical students perform painful procedures on patients solely to increase their skill	3.00	1.81	5.43
Follow the physician's request not to discuss code status with a patient	3.41	1.59	5.42
Work with support personnel who are not as competent as patient care requires	3.37	1.59	5.36
Ignore situations in which patients have not been given adequate information to insure informed consent	3.56	1.44	5.13
Work with non-licensed personnel who are not as competent as patient care requires	3.00	1.59	4.77
Assist a physician who performs a test or treatment without informed consent	3.08	1.48	4.56
Follow the physician's request not to discuss code status with the family when the patient becomes incompetent	3.23	1.38	4.46
Give medication intravenously during a code with no compression or intubation	2.58	1.52	3.92
Increase the dose of intravenous morphine for an unconscious patient that you believe will hasten the patient's death	2.30	1.70	3.91
Carry out a work assignment for which I do not feel professionally competent	3.85	0.96	3.70
Ask the family about donating organs when the patient's death is inevitable	2.93	1.26	3.69
Not being able to offer treatment because the costs will not be covered by the insurance company	3.33	1.00	3.33
Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it	3.22	1.00	3.22
Discharge a patient when he has reached the maximum length of stay based on diagnosis related grouping (DRG) although he has many teaching needs	2.81	1.04	2.92
Follow the physician's order not to tell the patient the truth when he/she asks for it.	3.30	0.85	2.80
Ignore situations of suspected patient abuse by caregivers	3.11	0.81	2.52
Be required to care for patients I am not competent to care for	3.19	0.70	2.29
Follow the physician's request not to discuss death with a dying patient who asks about dying	3.56	0.63	2.24
Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	3.04	0.51	1.55
Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay	3.11	0.41	1.27
Provide better care for those who can afford to pay than for those who cannot	2.67	0.37	0.99
Respond to a patient's request for assistance with suicide when the patient has a poor prognosis	2.67	0.11	0.29

The Moral Distress Scale was created by Mary C. Corley, RN, PhD. Those wishing to use the scale must obtain permission via e-mail from Dr Corley (mccorley@vcu.edu).

I find myself listening to report to get an assignment that excludes certain patients. (respondent 18)

After a stressful week—many deaths, families with unrealistic expectations—I will go to the step-down unit for a day. (respondent 9)

It feels like I have created a defense mechanism of just blocking a patient's death or inevitable death out of my mind. (respondent 18)

Some days . . . I see patients as “my job,” not “real people” with families. (respondent 27)

### Psychological Responses

It angers me when a doctor or nurse gives a patient or family “false hope” when they know the patient will not survive. (respondent 13)

It sickens me when we “pull out all the stops” on a patient who will never have any quality of life. (respondent 14)

I'm scared that I'm causing undue pain and suffering, and this causes me great distress. (respondent 15)

I have noticed experiencing anxiety and depression after taking care of patients. Then I also have a feeling of dread when I anticipate having to face the same situation returning to work. (respondent 19)

I feel nurses, especially myself, have traumatic stress disorder. I'm more anxious and nervous the longer I'm in this profession . . . . (respondent 21)

*“I'm scared that I'm causing undue pain and suffering, and this causes me great distress.”*

### Physical Responses

My experiences have manifested themselves by impacting my ability to set aside my thoughts for the day and being able to sleep restfully and peacefully. (respondent 12)

I've gone through many phases of moral distress from restless sleep to little sleep . . . . (respondent 21)

Some days I feel sick. (respondent 13)

*“Some days I feel [physically] sick.”*

### Interactions With Coworkers

I try to keep a positive attitude at work with humor and food. (respondent 24)

Most nurses will discuss feelings with other nurses. I think this is good, but there are those who probably don't vocalize it, and it affects them negatively though they might not know it. (respondent 16)

### Self-image

Patients and families create a heavy burden on my moral health and make me feel I have a poor attitude about life. . . . (respondent 18)

My personality has changed to cynical, suspicious, unhelpful, lacking enthusiasm, unwilling to help others. (respondent 21)

### Spirituality

If anything, my religious beliefs have gotten cynical. (respondent 19)

I have always had faith in God, but I'm more religious now. (respondent 21)

### Health-Related Actions/Decisions

For my husband and I, our New Year's resolution is to fill out advanced directives—we want both our families to know our wishes. Our discussions started after I told him about patients I encounter. (respondent 13)

Due to my experiences, I have had discussions with my family members regarding their wishes as well as mine. (respondent 15)

It makes me think of someone in my family dying and how I want to die. (respondent 27)

I do not wish to give my liver for donation due to the way liver transplant is done here. (respondent 1)

I no longer donate blood after “wasting” blood products on patients who are terminal. (respondent 4)

I have taken my name off the organ donor listing. (respondent 2)

I am ashamed to say that I have thought seriously about not being an organ donor. (respondent 14)

I will NEVER donate my liver. I haven't donated blood in years. (respondent 22)

I've changed my beliefs about organ donation after seeing patients with liver transplants who return after binge drinking or drug use. (respondent 10)

*“I am ashamed to say that I have thought seriously about not being an organ donor.”*

### **Feelings of Powerlessness, Hopelessness, and Lack of Support**

In addition to descriptions of the impact of moral distress, some nurses included descriptions of specific patients and circumstances associated with great moral distress. As well, feelings of powerlessness, hopelessness, and lack of support emerged.

It is extremely difficult to be in a situation you know is hopeless but all available measures are being implemented to prolong a patient's life and you're powerless to do otherwise. (respondent 15)

No one really helps nurses. We live with this day in and day out. No therapy. No intervention. Nothing. We just go on to the next patient. (respondent 21)

### **Discussion**

We did this study because we suspected that moral distress was an important problem for nurses practicing in our MICU. Although the respondents' individual experiences varied considerably, we confirmed that nurses experienced moderate levels of moral distress overall. We sought to determine clinical situations associated with high levels of moral distress. We found that

high levels (intensity and frequency) occurred when nurses felt they were providing aggressive care to patients who would not benefit. This finding was not surprising because nurses have long identified distress in this context.

In 1981, Davis<sup>7</sup> reported survey results that described the content of ethical dilemmas faced by nurses. Prolonging life with heroic measures was identified by nurses in the United States as one of their most frequently occurring dilemmas. In the study by Wilkinson<sup>3</sup> of situations in patients' care that were associated with moral distress, prolonging life and performing unnecessary tests and treatments on terminally ill patients were mentioned most often. Omery et al<sup>8</sup> conducted surveys between 1986 and 1993 to identify the ethical issues faced by hospital-based nurses. Issues related to quality of life, do-not-resuscitate decisions, conflicts over what is in a patient's best interest, and dying with dignity ranked highly in those surveys. The percentage of nurses who practiced in adult critical care who reported being faced with quality-of-life issues was higher than that of nurses from other practice areas.

In a study by Corley et al,<sup>9</sup> 106 nurses working on medical-surgical units reported levels of moral distress similar to those found in our study (MDI = 3.64 and MDF = 1.45). Nurses in another study by Corley et al<sup>6</sup> reported that working with levels of staff the nurses considered “unsafe” was the source of the highest levels of moral distress. The source of the second highest levels was “carrying out orders for unnecessary tests and treatments for terminally ill patients.”

Nurses' experiences of moral distress most likely are increasing in intensity and frequency. The ever-increasing number and complexity of life-supportive techniques, limitations in predicting mortality, heightened expectations of patients and patients' families for “good” outcomes, organizational reforms to increase efficiency, and institutional constraints such as staffing shortages and high workloads most likely contribute to the pervasiveness of experiences of moral distress in critical care.

In the United States today, 1 of every 5 deaths involves hospitalization with use of intensive care.<sup>10</sup> As highlighted in a recent review,<sup>11</sup> the distinction between critical illness and terminal illness is often not easily made. Because death may not be predictable, many ICU patients are dying while receiving aggressive interventions to extend life. This situation is a potential source of confusion, conflict, and distress among caregivers, patients, and patients' families.

Evidence suggests that patients and their families are not satisfied with end-of-life care in the ICU.<sup>12</sup> Nurses also are often dissatisfied and distressed in providing end-of-life care. Recurring themes reported by nurses

include concern about overuse of life-sustaining technologies, a profound sense of responsibility for patients' welfare, a desire to relieve suffering, and perceived unresponsiveness of physicians toward that suffering.<sup>13</sup> A recent report<sup>14</sup> of moral distress in attending physicians and nurses in adult ICUs suggested that physicians also experienced moral distress, although to a lesser degree overall than did nurses. Again, situations in which caregivers felt compelled to provide aggressive care at the insistence of others engendered the most distress for both professional groups.

We can only speculate about the correlation between intensity of moral distress and years of nursing experience. Most likely with increasing years in the nursing profession, the cumulative weight of distressing experiences also increases. If so, this increase argues against "desensitization" to moral distress over time. We wondered if the more experienced nurses provided more evidence of distress on the free-text part of the questionnaire. We were unable to discern any such overall pattern.

Implications of moral distress have been little explored. What data are available have been primarily on the impact of moral distress on job dissatisfaction, burnout, and loss of nurses from the workplace and the profession. We certainly found these implications of moral distress experiences in our study. Wilkinson<sup>3</sup> summarized nurses' reports of other detrimental consequences of moral distress, including loss of self-worth, effects on personal relationships, psychological effects, behavioral manifestations, and physical symptoms. All of these outcomes were reported by the respondents in our study.

The impact of experiences of moral distress on attitudes about advance directives was not unexpected. Gillick et al<sup>15</sup> studied preferences of nurses and physicians for care at the end of life and found that nurses were unlikely to desire aggressive treatment if the nurses were terminally ill, demented, or in a persistent vegetative state. Lipson et al<sup>16</sup> found that nurses favor use of advance directives and think that advance directives are an important influence in determining treatment of patients who have lost competence. It is not known if experiences of moral distress influence the execution of advance directives.

A previously unreported finding was the recurrent association of moral distress with unwillingness to participate in blood and organ donation. This disinclination to donate blood and organs coincides with a relative scarcity of blood products and organs for transplantation in the United States and a critical disparity between demands and available resources. The respondents frequently mentioned distress at seeing blood

products and organs "wasted" on patients who were not expected to benefit from transfusion or transplantation.

A particularly large number of liver transplants are performed at Rush University Medical Center, and patients under evaluation for transplant or retransplant may be cared for in the MICU. In our sample, transplant-associated distress was related specifically to patients who received a liver transplant despite recent alcohol use or who were considered for a second transplant after suspected drug- or alcohol-related graft failure. Such patients had been present in the MICU before data collection for our study. We suspect that the frequency with which the bias about liver donation was mentioned was influenced by those recent distressing experiences. We also do not know whether the bias against donation of livers extended to organ donation in general.

Importantly, nurses are relied on to have positive attitudes toward donation and to be "vital links" in encouraging others to donate.<sup>17</sup> Further exploration of moral distress as a factor influencing attitudes toward blood and organ donation is warranted. Additional study should include the extent to which morally distressing experiences affect personal decisions to donate blood products and organs and whether donation by others is discouraged as well.

*Negative feelings about blood and organ donation may relate specifically to recent distressing experiences in the medical intensive care unit where the study was done.*

The limitations of this exploratory study must be considered in interpreting the results. The study involved a small sample of nurses from a single unit of a single medical center, and the findings may not be representative of the experiences of moral distress of critical care nurses in other settings. The clinical situations included in the MDS instrument do not necessarily reflect the breadth of morally distressing circumstances, and scenarios that result in marked moral distress may have been missed. Finally, implications of experiences of moral distress were simply noted, and no information is available on the degree, significance, or pervasiveness of any of the implications reported.

Findings from this study have been shared with the MICU nursing staff. One important initial outcome of allowing experiences of moral distress to sur-

face and receive respectful attention was the relief some nurses expressed. Specifically, a number of nurses indicated that they had worried that their personal experiences of distress were unique and disproportionate to what other nurses experienced. These nurses were reassured to learn that they were not alone in the intensity and frequency of the distress they faced.

*Specifically, a number of nurses indicated that they had worried that their personal experiences of distress were unique and disproportionate to what other nurses experienced.*

## Conclusions

Critical care nurses' experiences of moral distress are intense and frequent. Providing aggressive care to patients not expected to benefit from critical care is a main source of moral distress. Critical care nurses can identify important and wide-ranging implications of moral distress that extend well beyond job satisfaction and retention. Moral distress is a serious issue in the workplace and deserves urgent and extended attention. Research on interventions to address moral distress is also needed.

Commentary by Mary Jo Grap (see shaded boxes).

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