

Listening to Nurses' Moral Voices: Building a Quality Health Care Environment

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Abstract

In this paper we describe a research project in nursing ethics aimed at exploring the meaning of ethics for nurses providing direct care with clients. This was a practice-based project in which participants who were staff nurses, nurses in advanced practice, and students in nursing were asked to tell us (or describe to us) how they thought about ethics in their practice, and what ethical practice meant to them. We then undertook to analyze, describe and understand the enactment of ethical practice, the opportunities for and barriers to such enactment, as well as the resources nurses need for ethical practice. We drew out implications of these findings for nursing leaders.

We identified practice realities that create a climate for ethical or moral distress, and the way in which nurses attempt to maintain their moral agency. Practice realities included nurses' ethical concerns about policies guiding care; the financial, human and temporal resources available for care; and the power and conflicting loyalties nurses encounter in providing good care. Maintaining moral agency involved use of a variety of ethical resources and the identification of resources needed to provide good care, as well as the processes used to enact moral agency.

Nurse leaders are also moral agents. Important implications of these findings for nursing leaders are that they need moral courage to be self-reflective, to name their own moral distress, and to act so that their nursing staff are able to be moral agents. Nurse leaders need to be the moral compass for nurses, using their power as a positive force to promote, provide and sustain quality practice environments for safe, competent and ethical practice.

Achieving practice environments in which nurses can engage in "safe, competent and ethical practice" (CNA Code, 2002a) is one of the more difficult challenges nurse leaders face. Problems for nurse leaders in fulfilling the

mandate of providing and maintaining acceptable practice environments are long-standing. Political, economic and organizational ideologies often create a climate less than ideal for such nursing practice. In fact, many maintain that health care environments today constrain nurses in their ability to practice ethically, (Varcoe & Rodney, 2001; Yarling & McElmurry, 1986; Rodney, 1997). This, in turn, often leads to the experience of ethical or moral¹ distress (CNA, 2002a; Rodney & Starzomski, 1993; Webster & Baylis, 2000). Moral distress² is defined by Jameton (1984, p.6) as a situation in which a nurse would know "...the right things to do, but institutional constraints make it nearly impossible to pursue the right course of action". Others define moral distress more broadly. Webster and Baylis (2000, p.218) state that moral distress may arise "...when one fails to pursue what one believes to be the right course of action (or fails to do so to one's satisfaction)". This may include "...an error in judgment, some personal failing..." or other circumstances truly beyond one's control such as an institutional constraint. When nurse leaders are not able to develop practice environments in which nursing practice can flourish, they also experience moral distress.

To engage in "safe, competent and ethical practice", as required by the Canadian Nurses Association Code of Ethics for Registered Nurses (2002a), involves an understanding of ethics and ethical conduct, support for ethical practice, and courage and commitment to voice moral concerns and be heard. Increasingly, safe, competent, ethical nursing practice is threatened and the anguish of nurses providing direct care is becoming increasingly visible. Being forced to make do with casual employment, experiencing increased workload and increased job dissatisfaction, and being required to work overtime, are only some of the problems nurses face in the delivery of health care. That many nurses decide to leave Canada and/or to leave the nursing profession, is symptomatic of the fundamental problems nurses face in the delivery of health care (Baumann et al., 2001; CNA 2002b). For those who stay, there are many barriers to nurses' ability to engage in 'good nursing practice' (to be moral agents) at all levels of the health care system. Jacobs (2001) defines moral agency as "that property a person possesses of being able to reason, self-determine and ultimately act or be moral"³ (p. 32). Georges and Grypdonck (2002) consider moral agency as a central concept of ethical theory (virtue theory) that "refers to the nurses' status as moral agents arising from their commitment to patients" (p. 157), and therefore their ability to enact safe, competent, ethical practice.

While books and articles about nursing ethics are abundant in their descriptions of nursing ethics, the voice of practicing nurses about the meaning of nursing ethics in their daily practice is largely absent from such discussion. Studies that do convey the voice of nurses tend to focus on ethical issues nurses experience in their practice setting

(for example, Oberle & Tenove, 2000; Omery et al., 1995; Berger et al., 1991; Van der Arend & Van den Hurk, 1999); or how nurses deal with ethical dilemmas and ethical conflicts they experience (for example, Redman & Fry, 2000; Raines, 2000; Leners & Beardslee, 1997; Grundstein-Amado, 1993; Woods, 1999; Kelly, 1998; Lindseth et al., 1994; Uden et al., 1992. Georges & Grypdonck (2002) provide an excellent summary of these types of studies, all of which are important to our understanding of nursing ethics. However, our intent was to probe the meaning of nursing ethics for practicing nurses at a more fundamental level by accepting discussion of issues, dilemmas and conflicts, but continuing to press for the meaning of ethics for nurses providing direct care, a study goal similar to that of Smith and Godfrey (2002).

In this paper, we describe our research project aimed at exploring the meaning of ethics for nurses providing direct care, for nurses in advanced practice positions in nursing as well as several nurse managers, and for students in nursing. This was a practice-focused research project in which participants were asked to tell us how they thought about ethics in their practice. We then undertook to analyze, describe and understand the enactment of ethical practice, the opportunities for and the barriers to such enactment, as well as the resources nurses need for ethical practice, drawing out implications for nursing leaders.

Approach to the Study

A team of five nursing faculty members (later joined by five graduate students) began to question what ethics means to nurses providing direct care and what practicing ethically means to nurses. The study was designed as a qualitative, descriptive inquiry using the constructivist (naturalistic) inquiry described by Lincoln and Guba (1985). A dual mode of inquiry was employed with the descriptive work (what is) used to generate normative (value based) work of what should be (Jameton & Fowler, 1989). Focus groups were selected as our means of data collection because well conducted focus groups can minimize researcher influence on the data, can allow the participants in the group a good deal of control, and can provide a process for group members to build upon the responses of others in the group to create a synergistic effect conducive to high quality information (Morgan & Krueger, 1993; Wilkinson, 1998; Mandriz, 2000).

Eighty-seven participants were involved in nineteen focus groups: twelve of these were with nurses practicing in a hospital or community agency; four were with nurses in the third and fourth years of their BSN nursing program; three focus groups were conducted with advance practice nurses; and one which included nurse managers. The groups included nurses from a variety of communities, agencies and units including medical, surgical, maternity, long term care, critical care, emergency, operating room, psychiatry, rehabilitation, and oncology units, as well as

home care and community care. Two team members, one faculty member and one graduate student, serving as research assistant and observer, conducted the focus groups. All focus groups were audio-taped and transcribed, and both faculty and graduate students also took notes during the session. For student groups, every attempt was made to avoid undue influence of faculty on students, including having research assistants only as focus group facilitators. (There was one exception where, due to scheduling difficulties for the graduate students, one faculty member was involved in a student focus group along with a graduate student).

Ethical approval for the research was obtained from both the University and from the relevant research ethics and/or administrative committee for each unit involved in the study. Nurses from each unit or area were invited to participate through the researcher's presentation of the project at a regular staff meeting, through notices posted at the agency, through information given to a unit manager or through another nurse on the unit. Confidentiality upheld by the investigators was assured: focus group members were urged to respect the confidentiality of the group. Subsequently all identifiers were removed from transcribed interviews and field notes.

Data analysis was conducted by each team member reading a given transcript and doing her own thematic analysis. The team then met, and themes were discussed and modified as the data were reviewed within a given transcript and across transcripts. Field notes were used to supplement this process. Gradually relationships between themes were identified and descriptions of the findings developed. Once an overview of the findings was developed and reported, further analysis was conducted by sub-groups of the team to expand particular aspects of findings.

Findings

Several findings of particular significance to nursing leaders emerged from our data⁴. It was clear from the data that nurses providing direct care describe a relationship between their abilities to practice ethically in light of everyday realities and their experience of moral leadership in their places of practice. Nurses' abilities to practice ethically are inseparable from practice realities that can create a climate for ethical or moral distress. Specifically these realities were nurses' concerns about the ethical climate of the organization and the policies guiding care; the financial, human, and temporal resources available for care; and the power and conflicting loyalties nurses encounter in providing good care. Other findings included the ethical resources nurses utilize and the resources they need to provide good care, as well as the processes used to enact moral agency.

Organizational Climate and Policies Guiding Care

Throughout almost all transcripts there is evidence that the organizational climate, including policy development and implementation in agencies, is problematic for nurses. Sometimes this was due to lack of policy, sometimes to the presence of a binding policy and, more often, to an ambiguous policy. Examples of policies considered to be lacking include the absence of direction home care nurses (and some hospital nurses) experience in attempting to determine what constitutes a situation where a 'patient is a danger to himself', and how they should seek consultation and support from psychiatrists, police and others.

Nurses also have to work with policies considered too binding, such as the resuscitation policies predominant in the agencies studied. The number of cases where nurses indicated they were required to call a code that they considered not in the patient's best interest but because the policy required that they do so (usually because a "Do Not Resuscitate" [DNR] order had not yet been written), was overwhelming. In one case a nurse felt obliged to call a code on a patient who was 102 years old, because there was no order to the contrary. In other cases, patients near death were resuscitated because this policy was understood to require that particular action. Absent in most agencies (or unknown to the nurses) are resources to deal with unhealthy conflict generated by these types of policy-related issues. A healthy organizational climate should support and encourage raising ethical questions and engaging in ethical dialogue. But these nurse participants stated they often felt silenced.

Financial, Human, and Temporal Resources Available for Care

Another predominant theme was the nurses' concern about appropriate use of resources. They struggled with decisions made by others regarding the allocation of scarce resources. Sometimes these resources were used to sustain a patient's life; sometimes to keep a patient in hospital longer than nurses perceived to be appropriate based upon other physicians' common practices. In the nurses' view, the effect of such action was to waste precious financial, human, temporal, and emotional resources. One Canadian philosopher describes "maintaining life support when there is no justification for doing so" as poor use of community resources which unjustly denies health services to others (Doucet, 1992, p. 97), a sentiment shared by many of these nurses. For example, one student nurse noted the length of time staff had kept a terminally ill and deteriorating patient alive: she observed that apart from the monetary cost of these actions the emotional cost⁵ to the nurses was immense.

The person is basically dead. They're going to be dead,

whether you keep [the ventilator] on...they're not going to get better... You are wasting nursing staff. You're wasting nurses' emotional space.

In many situations nurses were critical of doctors, non-nursing leaders and nursing leaders who failed to address these types of conflicts, with a sense that the reason for non-action was guided by that individual's wish to not "rock the boat". They were particularly critical of medical staff who used resources in a way which brought no real benefit to the patient and thereby wasted nursing and other resources needed by other patients. The nurses perceived these situations to arise due to a failure of physicians to act; physicians indulging in excessive and unwarranted treatments to satisfy their own needs and interests and not the patients' interests; or as a function of poor communication with other health care team members. Because of this lack of meaningful communication nurses could not know the reasons for particular decisions and they did not have opportunity to be involved in discussions or decision-making.

Nurses in leadership positions in the advanced practice and management focus groups were extremely sensitive to their own potential to be too assertive about these types of ethical concerns out of fear that they might jeopardize their ability to act effectively in future. Some noted that on previous occasions the effect of continuing to raise their concern about an ethical issue was to be marginalized by the other administrators, for example, by not being invited to the meeting at which the issue was discussed. Yet, findings in the staff nurse data suggested that staff nurses believed their nurse leaders did not "rock the boat" enough, and that this was jeopardizing nurses' ability to practice safely and ethically.

Often the precious resource of *time* was noted as well. Throughout the focus group discussions the pressure of time and the need for time to do important physical or emotional work was emphasized. Clearly, the need for more time was considered a barrier to practicing ethically. While the need for "more time" was the operative description, nurses' discussions conveyed their struggles to practice ethically in the midst of demands of an increased workload, increased expectations, an increased volume of patients and a higher severity of patient illness. Nurses spoke about lack of time to listen to and support patients: they also spoke about lack of time for reflection on their practice with colleagues. They viewed such reflective sharing as vital to professional ethical practice.

I wish we had more of an opportunity to share with our colleagues... we have a very large staff, and I'd like to be able to draw on their experiences and their attitudes. It might reassure me in some ways in people that I do not know very well, that they're, ethically speaking, coming from a good place too.

Power and Conflicting Loyalties

There were many revealing instances where nurses described the significant amount of time they have to spend working around systems and hierarchies that do not work for them and do not benefit patients. Many of the structures and processes they try to overcome are a function of the power dynamics resident in the health care system. These dynamics can lead to strained relationships with physicians, with nurse leaders and with other health care team members. The strain arises due to the commitments nurses feel to the individuals for whom they care, and their desire to serve them first and foremost, which may become secondary to their need to attend to the physician's needs, or to the needs of a senior nurse colleague or nurse manager. Thus the hierarchical structures of health care which compete with the nurses' commitment to the individual being cared for (who should be the primary source of concern) create conflicting loyalties for nurses. Problems working these dilemmas through with physicians were paramount in the data and became more complex when decisions about allocation of resources were necessary to ensure quality patient care.

At times nurses were required to resuscitate patients when the nurses knew this intervention was contrary to the patient's wishes. Nurses indicated that in some cases it seemed 'customary' for doctors to abide by the wishes of the family, even if those wishes contravened the directive of the patient. Nurses were then caught with having to carry out the doctor's order which was against the patient's expressed wishes. Other studies in bioethics support the belief that nurses often know the client's wishes because they are well positioned to get to know what client's experiencing prolonged suffering or disability want at the end of life (Breier-Mackie, 2001). Lack of recourse to the physician's order and inadequate policy implementation create considerable emotional and moral or ethical distress for nurses on the front lines of care.

Some nurses described physicians as not willing to listen or to receive the nurse's point of view. For example, a physician told one student that her input about the person she was caring for (information that appeared to our team of researchers to be important for the person's care) was not appropriate since she was "the lowest person on the food chain". Another nurse noted the pressure she felt in dealing with, for example, ten cataract extractions per day as dictated by a particular surgeon. She stated that she had the emotional feeling that she was "practicing with a gun to her head".

Many times nurses described the way they tried to cope with these morally distressing situations. For example, nurses described their attempts to bring matters of inappropriate use of resources to the attention of others in the organization, and the futility of their attempts, even though they used the appropriate channels to try to bring about a change. Further, in a case where the competence of

the physician was in question, nurses voiced their concerns to the Chief of Staff and the Medical Director, carefully documented these concerns, wrote to the College of Physicians and Surgeons, and spoke to the Unit Director. But bringing attention to the physician's unsafe practices was extremely slow to be realized and, in the end, actions to limit that physician's unsafe practice were minimal.

Nurses in our focus groups often described physicians 'yelling' or otherwise taking out their anger on nurses, and decisions being "taken away" from nurses. Such behavior on the part of working colleagues adds to the moral distress nurses experience, and destroys collegial and trusting relationships. This has the potential to be highly detrimental to client care and to nurses' sense of self as moral agents. Denying nurses the ability to be involved in decisions or to make nursing decisions is also detrimental to good care. One nurse stated,

Not being allowed to make decisions is like atrophy of muscles – I can hardly remember being in control of my practice, of my ethics, of making these decisions – it's eroding.

Resources Utilized and Resources Needed to Enable Ethical Practice

Nurses noted their reliance on each other to deal with their ethical problems in practice. They commonly stressed the value of nurses having a chance to talk to each other and to find time to do so, while also noting that such time is largely unavailable to them during work hours. Some spoke about getting advice from their provincial registered nurses association. Some talked about the way they draw from ethics literature, and from ethics courses they had taken. Others spoke of the need for ethics workshops as in-service offerings, or simply their wish to have time available for ethics rounds or on-unit discussions.

Occasional reference was made to the potential use of ethics committees, although this resource was often noted as a distant and not well-known or trusted entity. Nurses conveyed their sense that their issues might not be well received and they doubted the level of support they might receive from an ethics committee. This is the same disturbing finding of a Canadian study completed almost ten years prior wherein nurses did not know or believe they could or would have good support from clinical ethics committees in their health agencies (Storch & Griener, 1992).

Almost all groups discussed the need for administrative support and for increased nursing leadership. Too often nurses described their nurse leaders as reluctant to raise ethical concerns or to advocate for clients or staff. Or they described them as invisible. One focus group, largely composed of nurse managers, initially spoke about 'having their hands tied', that is, not being able to effect change to accomplish goals they believed to be for the good. It was

only towards the end of the focus group session that they seemed to realize their own potential to do more to facilitate practice environments conducive to ethical practice.

Processes Used to Enact Moral Agency

Throughout the focus group discussions there was evidence of the nurses' struggle to become more thoughtful about themselves as moral actors or agents. They discussed the ambiguity, uncertainty and questioning of self they undertook and their need to gain confidence in their moral judgments and decisions to better enact their moral agency. In the process many described the way they tried to negotiate boundaries, engage in sensing or balancing responsibilities, or sometimes remaining stuck in-between. Their willingness to bend or break particular 'rules' and their willingness to name the unseen within the situation were ways in which nurses tried to prevent or mitigate unethical practices. The majority of these nurses were very clear about their responsibility to be moral agents, even if they were not always certain how to best do so. Some referred to other nurses or other health care team members as either not clear or not able to accept their responsibilities as moral agents. It seemed clear that the barriers previously discussed often interfered with the nurses participants' ability to enact their moral agency in practice.

Implications for Nurse Leaders as Moral Agents

Nurses in this study conveyed several notions about nurse leaders' actions, or more commonly, their inactions. Some remarked that nursing leaders were almost as powerless as staff nurses in being voiceless and unable to effect improved practice environments. Others expressed frustration that nurse leaders were unwilling to take the power that was perceived to be theirs. They also recognized that in failing to take that power, nurse leaders seriously compromised patient care. Still others were empathetic to nurse leaders who were considered to be captive to unreasonable managerial responsibilities. Only in occasional instances were nurse leaders actions described as helpful or supportive in the nurses' ability to be moral agents and to engage in safe, competent and ethical care.

To enact one's moral agency as a nurse leader involves having moral courage. In an article focusing on regaining nursing's moral voice its authors define such courage (Mohr & Horton-Deutsch, 2001):

Courage is the capacity to overcome fear and aversion in order to do what is morally right; it is opposite to cowardice. Courage is an attribute that we need in order to face all kinds of moral challenges. We need courage to overcome the peer pressure to 'go along and get along' (p.33).

Courage is also needed to name one's own moral distress.

Such an action allows leaders to name and accept the moral dilemmas and the moral distress of nurses providing direct care as those nurses attempt to enact their moral agency. Nurse leaders need to find their own level of comfort and balance in taking the moral authority for the patient/client care they possess. These leaders need to be a moral compass for nurses. They must support nurses' enactment of their moral agency for the enhancement of ethical practice in nursing to improve patient care and patient outcomes.

Moral courage and moral distress

From findings of this study we conclude that nurse leaders' must be ready to facilitate identification of ethical and moral issues, that includes translating the distress nurses are experiencing into actually naming the issues. This takes courage and commitment since naming these issues often leads to challenges from others and interim conflict for the nurse leader. Yet choosing not to name these issues places nursing leaders in the perceived position of being an accomplice to the creation of nurses' moral distress and perpetuates practices not in the best interests of clients.

At the same time, we recognize the dilemmas that nurse in leadership positions constantly stated regarding their need to speak but also to carefully "choose their battles", out of their concern that being excluded from meetings and decision-making might further disadvantage nursing. They described their difficulty in trying to find the right balance in the following statements:

Between pushing too much or not pushing enough. If you push too much, it ends up backfiring and ends up ruining your credibility and your opportunity to further influence. If you don't push enough, then you struggle with the ethical dilemma.

So part of our role is to turn up that can of worms and see what's underneath it and say we're not providing appropriate or adequate services here. And to start to create things that should be delivered to meet people's needs. And often you go head to head with management and administration around this over time because they're looking at resource allocation, utilization, fiscal limitations, etc....but in your heart you know that people's needs aren't being met.... So, its really tough to start drawing that line and knowing where you need to back off, for your career longevity, if you will, as opposed to fighting on principle.

While finding a balance is necessary, the nurses in our study point to the possibility that nursing leaders may be too timid in naming and speaking out about ethical issues and ethical comportment and, in this failure, they let their staff down. Clearly, we need more research to be able to better understand nurse leaders' experiences as they try to

act as a moral compass in our troubled health care era.

In the meanwhile, a first step for nurse leaders might be to engage in self-reflection to examine what is 'tying their hands' and why. Is it job security? Is it fear of censure? Is the rationale for their inaction grounded in patient good or are they focused on institutional good? Although these 'goods' should ideally be synonymous, when they are not in accord, the need to take action to bring them into alignment is part of a nursing leader's role as well. Or do they lack moral energy? Nurse leaders, like staff nurses, may be constrained moral agents. Aroskar (1998) notes that nursing ethics is not only about individual moral choice when the individuals involved are embedded in power structures. We found that when nurses, including nurse leaders, shared their stories of moral distress and moral challenge in the focus groups they seemed to become energized and started to generate potential solutions and strategies for addressing problems in practice, including dealing with some of the power structures that constrained their moral agency.

Once nurse leaders have understood their own moral agency more clearly, they can help nursing staff facilitate the identification of ethical and moral issues in order to translate that distress into naming those issues and their origins. A comment from one nurse indicates the importance of naming issues.

... and if you are being drained as a nurse then you are becoming totally desensitized then you no longer are being a nurse. You are just being a mechanical thing that does these things to the bits of flesh that come through the door.

Being a Moral Compass and Supporting Nurses Ability to be Moral Agents

Additionally, nurses need nursing leaders who can be a moral compass for them, leaders who are prepared to mitigate the disjuncture between moral intent and moral action to facilitate critical consciousness and change. They need to be able to influence the organizational climate by establishing the vision of good practice environments and making changes to make the vision possible (Storch, 1999). They need to be supportive of nurses to engage in good nursing practice. One nurse stated that leaders need to

...influence change, but to do it is such a way that you actually help people to move forward instead of feeling as though you have been critical of where they're at and therefore impeding them in actually moving ahead.

In short, they must work with staff to co-create a moral community, one in which there is respect for all who contribute to goals of safe, ethical and competent practice (Aroskar, 1995).

In almost all the focus group discussions there was reference made to the importance of nurses talking to

each other and sharing clinical stories as a powerful strategy for reflecting on practice while engaging in practice. Such clinical conversations communicate the substance of enacting ethical practice. Nurses consulting with one another in this manner to share clinical ethical judgments within nursing must become a clinical event, i.e., a part of nursing practice. With time as such a precious commodity for nurses in the current health environment, it is easy to ignore the importance of these types of conversations⁶. Yet, making space for nurses' stories helps to expose the meanings that constitute and sustain ethical practice, and makes visible the multifaceted and complex nature of nurses' work life. These same findings have been borne out in other studies, for example, Oberle and Tenove (2000) state that their study findings suggested that to support public health nurses' practice, these nurses needed opportunities "to discuss issues, engage in values clarification, and support and mentor one another" (p. 436). Similarly, a study of a critical care unit findings indicated that the essential part of ethical decision-making was the team conference when "the actors come together" for discussion "in an environment of openness and respect" (Bunch, 2001, p.66). Most importantly, consulting with one another and sharing perspectives can initiate the dialogue of moral action.

By working to create infrastructure for nurses to share their clinical narratives and work collaborations, nurse leaders can be effective in transforming nursing practice. By listening to nurses' moral voices, rather than insisting that they "cope", nurse leaders can foster such dialogue and help break the silence of nurses. They may also discover that by doing so they are energized and empowered to exercise their own moral authority in more meaningful ways. Those who rely on their leadership can then begin to see the way in which changes can happen with collective engagement.

Conclusions

Nurse leaders' moral agency involves being moral leaders in health care and nursing. This is not common language in many texts or articles on nursing administration, nursing management or even nursing leadership. Yet, the need for nurses in leadership positions to recognize their moral authority and to demonstrate their moral courage is desperately needed for the benefit of practicing nurses and for patients.

Participants in our focus groups (staff nurses, student nurses, and advanced practice nurses) told us how ethics relates to their practice in powerful and meaningful ways. This has particular meanings for nursing leaders, and there are particular commitments they need to make. We have already discussed nurses' need for time to be moral agents and time to talk about moral commitments, moral distress and moral action with their nursing colleagues.

For nurse leaders, this means placing a priority on

advancing models of care and nursing staff mix which support safe and ethical practice to allow nursing and health team consultations to become a norm of nursing practice. In addition, nurse leaders may want to consider planning for ethics rounds and/or workshops and continuing education courses on ethics for staff nurses. Professional associations, such as the Canadian Nurses Association and almost all provincial nursing associations are active in preparing ethical issue focused documents or ethical guideline documents to bring to such discussions. Such formal offerings can help nurses to “know themselves” and can assist them in developing greater “ethical fitness” (Kidder, 1995; Johnstone, 1999; Storch, 1999). The presence of well-functioning clinical ethics committees can also be a significant resource to nurses in their quest for constructive interdisciplinary dialogue on ethical problems.

Focusing attention on nursing’s contribution and its benefits to client care/service is important work of nursing leaders. For such a re-focusing to occur, the need for quality work environments must be seen as a top priority as well, so that excellence in patient care (i.e., excellence from the client’s perspective) can be realized. Nurses need to feel safe and secure in their work environments, and to feel a sense of appreciation and belonging in their workplaces in order to give to others that sense of feeling safe, secure and cared for. Nurses need encouragement to speak about conflict and to bring their ideas for solutions and revolution forward. And their voices need to be heard and regarded as equally credible to the voices of physicians and other professional workers. In our study, as well as the studies of others, relationships with other health professionals “were a source of considerable moral distress” for nurses (e.g., Oberle & Tenove, 2000, p. 436). Thus, there is a pressing need for nurse leaders to support nurses in their efforts to have their voices heard in interdisciplinary dialogue, and to be treated with respect.

While considerable discussion has been directed towards quality work environments for nurses, what seems to be minimized in such discussion is the ultimate goal, i.e., the reason for needing such environments. The freedom to be a moral agent, to be able to “do good” for clients, must be seen as a priority reason for improving work environments. This does not go without saying. It needs to be spoken and written: it needs to be ‘named’. Naming the value of the client’s well being is, after all, of high priority in the Canadian Nurses Association Code of Ethics for Registered Nurses (2002a):

Nurses must provide care directed first and foremost toward the health and well-being of the person, family or community in their care.

In fact, one might question whether the “burn-out” and low morale in current nursing work environments is in

large part a function of continued and unresolved moral distress leading to moral residue⁷ (see Rodney & Starzomski, 1993). When nurses are not able to keep individual, family or community needs in the foreground of their practice, their ability to be moral agents is removed.

Finally, using nursing’s power and moral authority is essential. This is highly relevant to the findings of our study. The importance of speaking up and speaking out are essential aspects of nursing leadership – whether that involves the safety and support provided to others to enable them to use their voices to be heard, or whether it is the voice of the nursing leader who has a commitment to speaking up and speaking out (Buresh & Gordon, 2000). Student nurses in our focus groups, in particular, marveled at how easily other professionals dismissed nurses’ voices. One commented:

I just don’t see nurses feeling like they have any power and they act like they don’t, which becomes a concern for the patient.

Our findings indicate that nurses’ decisions not to use their power jeopardizes ethical practice for students who look to nurses and nurse leaders as role models; for staff colleagues; for the nurses themselves; and for their clients. On the other hand, the support nursing leaders provide to staff nurses to practice ethically, to raise questions and concerns, to advocate, and to act is powerful and immeasurable. Power is a positive force and can be used wisely to effect change throughout the health care system and to enhance ethical practice.

The power of the execution of moral agency rests with nurses themselves and will not be threatened if the values and personal virtues that support those values are considered “nonnegotiable” in both theory and practice (Jacobs, 2001, p. 32).

Nurses at staff, administrative and leadership levels in the organization are often placed in situations where they are the only ones who can speak up or speak out about worrisome or unethical practices. There is a very important link between ethics and power. The voice of a nurse raising legitimate ethical concerns is an important way to unleash the power to promote, provide and sustain quality practice environments for safe, competent and ethical practice.

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Endnotes

¹ In this article the terms ethical and moral are being used interchangeably. While Storch prefers to define moral in reference to 'what' action is taken, reserving ethical for 'why' such a choice of action would be made, there appears to be a trend in the literature to utilize the word *moral* more extensively and more synonymously with ethical. Given the various descriptors attached to the term moral throughout this article, readers should read moral as synonymous with ethical.

² Moral distress has many definitions but all converge to situations in which a "moral choice cannot be translated into moral action" or where what one believes to be the right course of action cannot be accomplished due to circumstances beyond one's control. These may include perceived "constraints imposed by the institution, the social structures of health care and prevailing role relationships"

that preclude the pursuit of the right action (Webster and Baylis, 2000, p. 218). Varcoe and Rodney (2001) define moral distress for nurses as “situations in which they cannot fulfill their moral responsibility and accountability, and they are overwhelmed by ethical problems” (p. 114).

³ Jacobs identifies three attributes of moral agency to include “...qualities of mind and character that the one (in this case the nurse) holds as her own as an individual not necessarily as based on her role as nurse, accountability to herself as an individual person and as a nurse, [and] confidence in the moral judgments and decisions she makes” (p.32). Rodney (1997) defines moral agency as nurses enacting their professional responsibility and accountability through relationships in particular contexts.

⁴ See Hartrick Doane, G. (in press) Am I still ethical? The socially mediated process of nurses’ moral identity. Nursing Ethics, and Rodney et al. (in press) Navigating toward a moral horizon: A multi-site qualitative study of nurses’ enactment of ethical practice Canadian Journal of Nursing Research, and Varcoe et al. (in press), for further analysis of findings.

⁵ Until recently, there has been limited recognition of emotions in nursing and nursing ethics. Nursing leaders dating back to Nightingale have often counseled nurses to hold back their emotion. It would have been assumed, then, that in cases like this one described by the student, nurses would not feel the emotional impact of looking after someone whom they considered dead, since such duties were a normal part of their everyday work. However, scholars in philosophy and nursing such as Little (1995) have urged that attention be given to affect in ethics, meaning attention to desires and emotions. Little (1995) claims it is through use of emotion that nurses can understand the experience of the person they are caring for and be sensitized to the ethical problems they face. Norvedt (1998) also considers emotional understanding (including both affective and cognitive components) as “critical for comprehending the experience of patients and thus essential for the moral performance of nurses” (Georges & Grypdonck, 2002).

⁶ During the course of this study, the researchers became increasingly aware of the limited opportunities nurses have to simply talk to each other. With cutbacks, casualization, and various efficiencies developed for the delivery of care, regular times for nurses to engage in discussion, such as morning report and or personal reporting and discussion with each shift change are rare and this has left most nurses working in relative isolation from each other. We found that opportunities for developing trusting relationships with colleagues have virtually been lost. This has a significant impact upon many aspects of nurses’ work. The most

significant impact has been to silence the moral voice of nurses, and to deny them the opportunity to discuss ethical challenges in their work and share their stories of dilemmas and distress, so that they can more effectively deal with their everyday ethics.

⁷ Moral residue has been discussed in an article by Webster and Baylis (2000) as ‘that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised. These times are usually very painful because they threaten or sometimes betray deeply held cherished beliefs and values. They are also lasting and powerfully concentrated in our thoughts; hence the term moral *residue* (p. 218).