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## Features

# Moral Agency, Moral Imagination, and Moral Community: Antidotes to Moral Distress

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### ABSTRACT

Moral distress has been covered extensively in the nursing literature and increasingly in the literature of other health professions. Cases that cause nurses' moral distress that are mentioned most frequently are those concerned with prolonging the dying process. Given the standard of aggressive treatment that is typical in intensive care units (ICUs), much of the existing moral distress research focuses on the experiences of critical care nurses. However, moral distress does not automatically occur in all end-of-life circumstances, nor does every critical care nurse suffer its damaging effects. What are the practices of these nurses? What specifically do they do to navigate around or through the distressing situations? The nursing literature is lacking an answer to these questions. This article reports a study that used narrative analysis to explore the reported practices of experienced critical care nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment. A major finding was that these nurses did not report experiencing the dam-

aging effects of moral distress as described in the nursing literature. The verbal communication and stated practices relevant to this finding are organized under three major themes: (1) moral agency, (2) moral imagination, and (3) moral community. Further, a total of eight subthemes are identified. The practices that constitute these themes and subthemes are further detailed and discussed in this article. Understanding these practices can help mitigate critical care nurses' moral distress.

### BACKGROUND

Moral distress has been recognized and studied for more than 30 years. The concept was first introduced in 1984 by philosopher Andrew Jameton, who defined it as the feeling experienced "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."<sup>1</sup> Three years later, Judith M. Wilkinson extended Jameton's work by further exploring the phenomenon of moral distress as experienced by staff nurses working in hospitals.<sup>2</sup> She looked specifically at the kinds of cases that caused moral distress for nurses and discussed both the types of situations and moral frameworks involved.

The cases mentioned most frequently by the nurse subjects were those concerned with prolonging life. The moral issues mentioned most often were (1) harm to the patient in the form of pain and suffering and (2) treating persons as objects, or dehu-

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manizing them. Given these findings, it is no surprise that much of the subsequent nurses' moral distress research from 1987 forward focuses on experiences in critical care settings.

Patricia Rodney was one of the first to further moral distress research by examining the experience specific to nurses caring for dying patients in critical care settings.<sup>3</sup> The results of her study found "senselessness" to be a central theme of critical nurses' perspectives on prolonging the dying process. She found that these nurses experienced corresponding moral distress that resulted in feelings of resentment, frustration, and sorrow.

Continued studies confirmed that the majority of clinical situations reported to cause critical care nurses to experience moral distress were related to end-of-life care, and the highest levels of moral distress were found to be associated with providing aggressive treatment to patients who were not expected to benefit from that provision.<sup>4</sup> The reasons nurses felt futile care was provided included demands by patients' family members, the lack of timely or skilled communication, and the lack of consensus among the treating team.<sup>5</sup> In morally distressing situations related to the end of life, nurses described negative consequences for themselves, patients, and families. For the nurses, these negative consequences included psychological and physical exhaustion, decreased morale, and decreased job satisfaction.<sup>6</sup>

While previous studies acknowledged both the institutional and individual components of moral distress, there was little written that offered theoretical explanation of how these components were related. Elizabeth Peter and Jean Liaschenko studied moral distress within the context of feminist moral theory, concentrating on the work of Margaret Urban Walker and Hilde Lindemann.<sup>7</sup> Feminist moral theory sees morality as a set of socially embodied practices that occur between people as they account to each other. Walker described moral identity as an accounting of what a person responds to, takes responsibility for, cares for, and values.<sup>8</sup> Under this lens, Peter and Liaschenko described moral distress as "the response to constraints experienced by nurses specific to their moral identities, responsibilities, and relationships."<sup>9</sup>

Given the strong relationship between moral distress and aggressive end-of-life treatment, Peter and Liaschenko argued that the goal of healthcare should be one of healthcare professionals working together in a shift away from prolonging life at all cost to the relief of suffering.<sup>10</sup> This shift is challenging in a culture in which the boundary between not enough

treatment and too much treatment is difficult to establish.<sup>11</sup> Perceptions vary between physicians, nurses, and family members. More so than others, critical nurses accept the reality of death and are committed to making it as comfortable as possible, despite the "paradigm of curing" rather than a "paradigm of caring" that is prevalent in critical care environments.<sup>12</sup>

Critical care nurses have reported moderate levels of moral distress overall.<sup>13</sup> They cited organizational, professional, and emotional stressors.<sup>14</sup> Emotional stressors included value conflicts, lack of emotional support, and dealing with the suffering of patients and families. Professional stressors included lack of end-of-life competencies, difficulty communicating with families, and difficulty collaborating with the medical team. Organizational stressors included the lack of a palliative care approach, inter-professional mistrust and conflict, and lack of continuity in life support and treatment plans.

Moral distress has a negative impact on the healthcare work environment. One study found that one in three nurses experienced moral distress.<sup>15</sup> Another study found that nearly 50 percent of nurses have acted against their conscience in providing care to terminally ill patients.<sup>16</sup> Most critical care nurses do not feel their nursing education prepared them to provide quality care to the dying and their loved ones.<sup>17</sup>

Since not every critical care nurse experiences the damaging effects of moral distress, there is much to be learned from the reported practices of those who do not. Although rich in identifying the presence of moral distress in ICUs and its negative consequences for nurses, the literature is lacking in information about those nurses who manage to avoid or navigate through it. This article reports the second major finding of a study of experienced critical care nurses who are comfortable with dying patients, which described their communication with families and physicians to negotiate consensus on withdrawing aggressive treatment and shifting to comfort care.<sup>18</sup> This finding concerns the apparent absence of moral distress in the nurses. We document the specific practices reported by these experienced critical care nurses who were able to navigate around or through morally distressing situations.

## METHOD

### Research Design

Narrative research interprets the meaning of actions and events experienced by individuals or groups to describe why something happened as it

did.<sup>19</sup> An understandable plot or story line is achieved by linking together actions and events, organizing them into a schematic whole. The overall plot is constructed by highlighting common actions and events, identified as themes. A hermeneutic interpretive technique is used to analyze the data and create the story from narrative examples that construct the plots and themes.<sup>20</sup> These plots and themes explain the overall story. Narratives from reported practices are valuable for illuminating actual practices.

### **Participants and Settings**

A volunteer sample of 19 critical care nurses participated in the study. These nurses represented four ICUs located in a large teaching hospital in the midwestern United States, including neurological, medical, cardiovascular, and cardio-thoracic surgical units. The invitation to participate offered the options of self-nomination or peer-nomination. All participants were self-nominated.

Inclusion criteria for this study included a minimum of five years' experience, a work schedule of at least half time, being comfortable with dying patients and their families, and having excellent communication and pain and symptom management skills. The average age of these nurses was 48, and their critical care experience averaged 17 years. Of the 19 participants, 13 (68 percent) reported they had no education in death and dying. The remaining six participants (32 percent) reported they had education in death and dying through continuing education programs.

### **Data Collection**

Principal investigators collected the data between January and April 2012. All ICU nurses in the teaching hospital were invited to participate by letters in their mailboxes, and copies were also sent to them via email. The letter detailed the study and inclusion criteria and instructed interested nurses to contact the researchers by telephone to schedule an interview.

The data consisted of unstructured, audiotaped interviews conducted by the principal investigators that lasted approximately 90 minutes. Each participant was asked the following "grand tour" question: "Tell me about stories where you were able to negotiate with families and physicians to get everyone on the same page regarding withdrawal of aggressive treatment." In the interview process, particular attention was paid to the temporal structure of the narrative to gather sequenced narrative information.<sup>21</sup> The researchers followed the lead the partici-

pant provided, asking clarifying questions throughout the interview.

The research team used the consensual validation method<sup>22</sup> and unanimously agreed that the 19 interviews provided sufficient data to answer the research aim. This richness of the data was used as the criteria for ending data collection. The interview data provided ample material for numerous thick descriptions.

The audiotaped interviews were professionally transcribed into written text, and checked for accuracy of transcription. The written interviews were subsequently coded in ATLAS.ti, a computer software program designed to facilitate qualitative data analysis and research.

### **Ethical Considerations**

The institutional review boards at the researchers' university and the teaching hospital where the nurse participants were recruited approved the study. Participants provided written informed consent prior to their interview, and were paid an honorarium of US\$100 for their time. Each nurse was assigned a fictitious name for recording, transcription, and coding to ensure confidentiality. The de-identified transcripts were then stored in electronically encrypted files in a locked office.

### **Data Analysis**

The data were analyzed using a narrative, hermeneutic interpretive approach. The research team used the consensual qualitative research method, in which each researcher analyzes the data independently, followed by analysis by a team. The focus of the analysis is interpretive, and discussion moves between the original data and the emerging description of the plot and themes.<sup>23</sup>

In the interpretive process, it became clear that the nurse participants in the study did not demonstrate evidence of experiencing moral distress as described in the nursing literature. This subset of data was then further analyzed. The verbal communication and stated practices relevant to this finding were identified and categorized, first as plots, then abstracted to themes. Descriptions were written for each theme, and exemplars for each theme were selected to illustrate the descriptions. The actions and events that were interpreted as themes were identified and reported as three major themes and eight subthemes.

### **Rigor**

Narrative researchers have argued for acceptance of the validity of collected evidence and interpreta-

tion that is foundational to narrative analysis. The purpose of validation is to convince readers that the research assertions are strong enough to be a basis for understanding human behavior.<sup>24</sup> The researcher is responsible for ensuring that the participant's own voice is heard and the narrative is not primarily the interviewer's creation.<sup>25</sup>

Yvonne S. Lincoln and Egon G. Guba proposed four criteria for establishing trustworthiness in a qualitative study: (1) credibility, (2) dependability, (3) confirmability, and (4) transferability.<sup>26</sup> In later writings, they established authenticity as a fifth criterion.<sup>27</sup> All five of these criteria were met in analysis of the data in this study.

In this study, trustworthiness was ensured by the audiotaped interviews and their verbatim transcription. The professionally transcribed interviews were reviewed and further checked for accuracy by the researchers. The group dynamic ensured reflexivity, the process of examining both oneself as the researcher and the research relationship. Research team members made sure that one another's preconceptions did not influence interpretation.

This study, by using the same interview guidelines, careful documentation in ATLAS.ti, and the use of memos, maintained dependability for an inquiry audit purpose. Inter-coder checks were established, and category lists and themes were developed and managed via ATLAS.ti. Based on the narratives, thick, vivid descriptions were constructed and followed by illustrative data. It is the thick description in the findings that allow transferability to like contexts. The researchers mutually agreed that a point of data saturation had been reached because the team was no longer finding new information relevant to the themes.

## FINDINGS

Enacting moral agency, exercising moral imagination, and fostering moral community were the major themes that described how experienced critical care nurses navigated around or through morally distressing situations while working with families and physicians regarding the withdrawal of aggressive treatment. The specific practices that constituted these themes include: self-awareness, advocacy, empathy, ascertaining what the patient would want, envisioning and facilitating possibilities for a good death, supporting relationships, managing conflict, and doing moral communicative work. These practices are non-sequential and are often circular. However, each is discussed separately in this article for the sake of clarity (see table 1).

### Theme One: Moral Agency

*Moral agency* is commonly defined as an individual's ability to make a moral judgment based on a commonly held notion of right and wrong and to be held accountable for their actions. Nurses in this study shared stories that demonstrated strong moral agency that facilitated positive outcomes for both patients and their family members. The nurses consistently approached the moral issues embedded in their daily work in a caring manner with a primary focus on loyalty to their patients and a willingness to challenge hierarchies. They held themselves accountable for their actions and did not fail to act because of either external or internal constraints. The practices of (1) self-awareness, including accountability for self and one's skill, and (2) advocacy fostered their ability to work through these constraints.

*Self-awareness.* To be self-aware is to be conscious of factors that influence one's thoughts, feelings, and actions so that one has a reasonable idea of how and why one thinks, feels, and acts as one does. The nurses in this study understood and were able to articulate what it was about themselves that contributed to their skill and comfort working with families and physicians regarding the withdrawal of aggressive treatment. They knew the work of nursing, knew how to get the work done, and understood what makes them skilled. They clearly articulated their roles and responsibilities as they and others understood them, and held themselves accountable for their actions. They benefited from their own experience as did others. There were two aspects to their self-awareness: accountability for self as a moral agent in general and as a nurse in particular, and accountability for their skill, discussed below.

*Accountability for self* was the first component of the nurse participants' self-awareness. These nurses articulated their understanding of what it

TABLE 1. Themes and specific practices

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|    |   |
|----|---|
| 1. | Moral agency  |
|    | • Self-awareness  |
|    | • Advocacy  |
| 2. | Moral imagination   |
|    | • Empathy   |
|    | • Ascertaining what the patient would want                  |
|    | • Envisioning and facilitating possibilities for good death |
| 3. | Moral community   |
|    | • Supporting relationships                                  |
|    | • Managing conflict   |
|    | • Moral communicative work                                  |

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means to be a nurse and their willingness to accept responsibility for whom and for what is under their care. The responsibility they accepted was for the (1) professional knowledge and skills necessary to be a competent nurse, (2) knowledge and understanding of their own moral values, and (3) knowledge of their emotions and how their emotions influence their actions. They knew the emotional work involved in caring for the dying and recognized the need to manage the difficulties of the work. They were concerned not only with their own ability to manage the stress and complexity of working with dying patients, but also with how their colleagues managed this work. One participant described her concern this way:

**Irene:** I sometimes feel like nurses are different from the rest of the public because of what we experience at the bedside. . . . It worries me. I feel like I have coped with it very well, but who are we missing that takes it home and can't figure out how to bring it in their heart or how to release it?

**Interviewer:** And what's the "it" you're coping with?

**Irene:** When you value life and it's ended . . . it's been a traumatic end and you're seeing this happen in front of your very eyes. You're caring for that patient and trying to make it [the death] the best possible way and then you wrap him in a body bag, you zip him up, and call transport to take him to the morgue. You continue to do your job. . . .

The nurses benefited from their own experience and learned from that of others. They accepted responsibility for their particular stance on end-of-life care and recognized that people held different views. They cited the virtue of "wisdom" and the qualities of "confidence," "maturity," and "sensitivity" as important personal traits in doing this work well. As one nurse commented:

It's all in maturity and sensitivity, and respecting that we all have different perceptions and values, and we don't always have the right to put them onto other people. That's hard and it takes a lot of wisdom. **[Irene]**

Not only did these nurses take responsibility for what they knew, they recognized what they didn't know, and knew how to get the information they needed to act. A participant displayed this awareness and understanding in stating:

You need to know what you know. You need to know what you don't know. You need to know

where to go to get the answers to the stuff you don't know. It's that simple. Nobody is ever going to have all the answers. . . . Just be able to recognize what you know and share it. And be able to recognize when you don't know and say "I don't know." Those are not dirty words.

**[Anne]**

*Accounting for skill* was the second component of the participants' self-awareness. Here they were not referring to their clinical skills, but rather to communicative skills such as listening, interpreting body language and emotion, timing, and word choice. Many attributed this practical wisdom to longevity in their position and unit and learning from repeated experiences. A significant part of this development was learning from one another through the mutual sharing of experiences that also included feedback. One nurse described it this way:

Having a comfort level, being very close to someone you don't know at that most intimate moment when you're with someone who is maybe taking their last breath, how did I learn to do that except for experience and time? I wasn't taught that [formally]. I had situations. . . . Talking out loud sometimes is how you learn and also, because I share a story that reminds me of a story you're telling, then we learn from each other. . . . We teach each other without knowing about it. We observe each other. **[Irene]**

*Advocacy.* For the nurses in this study, the practice of advocacy was central to their moral sense of self and thus their moral agency. Their advocacy included speaking to the family on behalf of the patient and speaking to the medical team on behalf of the family on end-of-life matters. In these situations, nurses reported advocating for their patients by challenging families, physicians, or both to consider a change of direction from aggressive treatment to comfort care. To accomplish this they listened carefully, skillfully asked questions about families' and physicians' understanding of the situation and goals of care, and provided information. This communicative work kept the biographical life of the patient and that person's suffering body at the center of concern. The following nurses stated the importance of keeping the focus on the biographical life of the patient when speaking on behalf of the patient to the family:

I will remind them [the family] that this is about what Mary the patient wanted and what kind of things did Mary do? Was she real active? Was she this? Was she that? What would she think

about being on a ventilator and in a nursing home for an extended period of time, if not for the rest of her life? [Anne]

Because you know, it is about family, but it isn't about family. It's about what is best for that patient. And I think a lot of times with family members, they're thinking about what's best for them. But I've always got to remember that you've got to think, "What is best for her?" What is best for her may not be what is best for you. Family members may want the mother to live forever, but that's not what's best for her and especially family members that have a little bit of guilt. [Elaine]

### Theme Two: Moral Imagination

*Moral imagination* is a moral agent's active attempt to consider what moral decisions to make and what action to take. Strong moral imagination was an attribute of the nurses in this study. For them, it was a moral imperative to envision possibilities for a "good death" for each individual dying patient. In the context of considering withdrawal of aggressive treatment, the stories they shared demonstrated their ability to discern various possibilities for acting and to envision the associated benefits and harms. The specific practices the nurses discussed around moral imagination were (1) empathy, (2) ascertaining what the patient would want, and (3) envisioning and facilitating moral possibilities for a good death.

*Empathy.* Nurses' empathy for the patient and the family was key in helping families to make the transition from aggressive treatment to comfort care. The nurses in this study demonstrated their ability to figuratively put themselves in another's shoes and skillfully reflect that perspective to the family. They frequently cited aggressive treatment situations in which they asked loved ones "How would you feel if . . . ?" and "What would you want done if . . . ?". They shared stories that demonstrated reflective listening (offering back the speaker's idea to confirm their own understanding), thereby building trust, respect, and a safe environment conducive to decision making. This empathetic communicative work was a moral imperative for these nurses. As one participant indicated:

It was a tremendous outlay of energy on my part, but a lot of times when I'm working I'm thinking, if these people were my family, what would I want someone to do for them? How much would you put yourself out? How much does somebody help the ones that you love at the end of their life? [Ruby]

Empathy was also important so that nurses would not get lost in the routine of their work in which death was a significant part. Another participant shared:

Sometimes I think we've been through this so many times, but it's always that person's first time, so just go in, not being all-knowing. . . . I try to put myself in that family member's shoes and not say too much. Not to give too much advice, but rather just empathize with how hard this must be. [Olivia]

*Ascertaining what the patient would want.* In a medical culture where respect for autonomy and shared decision making have replaced traditional paternalism, unilateral withdrawal of aggressive treatment by physicians is not the norm. Today it is more common for families to demand further aggressive interventions, even when such treatment is not in the patient's best interest. Under such circumstances, it was important to the nurses in this study to ascertain what the patient would want.

The concept of ascertaining what the patient would want must be situated in the context of the larger study, which examined the communicative work that nurses do with families and physicians regarding the transition from aggressive treatment to comfort care. None of the nurse participants told a story of advocating for continued aggressive treatment when either families or physicians wanted to withdraw treatment. All of their narratives demonstrated their conviction that withdrawal of aggressive treatment and support of as peaceful a death as possible was in the best interest of the patient. In this study, ascertaining what the patient would want was not about getting an answer to questions of a technical sense—Would your family member want to have CPR or not?—but rather about answers to questions of an existential sense—What would it mean for your family member to live "like this"? One nurse shared:

If I can't talk to the patient, I will talk to the family and say, "Have you had a discussion with your loved one regarding what they would want as far as ongoing care for medical things?" Very often they will say, "Well, they just want to live," or they'll say, "Yes, Mom has been very clear to me that she does not want to be on the ventilator again," . . . or whatever it may be. [Fran]

In helping families to explore the meaning of "like this," the nurses used knowledge of the patient's biographical life and deteriorating status in attempt to show families that continued aggres-

sive treatment would not contribute to their loved one's flourishing.

A major way of helping families was to relieve them of the responsibility for authorizing withdrawal of aggressive treatment by reassuring them that they were not acting on their own, but rather as an important voice for their now-voiceless loved one. One nurse shared how she defended her patient's best interests by reminding family members of their appropriate role in decision making:

I'm not asking them to decide what they would want; I'm asking them to tell me what they know the patient wanted. It's important to me to make that distinction for them because it's important that the decision made is about what the patient wanted and it also gives them some absolution, if you will, of responsibility for the decision that they need to voice. [Anne]

*Envisioning and facilitating moral possibilities for a good death.* The nurses in this study sought to ensure that their patients' lives ended well and that the patients' deaths were morally acceptable and emotionally comfortable for their families. The nurses saw alternate ways of viewing a patient's imminent death. They often challenged families and physicians to consider whether continued aggressive treatment was sustaining life or prolonging suffering. One participant stated:

I guess it's how you want to view it. Do you want to view it that we can prolong your life or that we can prolong your suffering? We [ICU nurses] view it, a lot of times, as we can prolong your suffering. We would, quite often, choose to end aggressive treatment much sooner than family members will. And even physicians sometimes too, just don't quit. They are so aggressive and the prognosis is so poor. [Natalie]

This presentation of an alternate view was important in helping families and physicians to come to a mutual understanding of what was happening to the patient. Working to provide a good death involved transitioning from hope for a cure or a miracle to realization that death was inevitable. It was a moral imperative for these nurses to help families remember their loved one's death as peaceful. The following participants shared how they worked to facilitate this and prepare families for the emotional work of grieving:

The first thing I think to do is make them [the patients] look like the last hour wasn't a struggle, breathing tube or bleeding or messy. . . . So the first thing we did we just got him washed up

and cleaned. I said to bring the family in and I had no words. I didn't have any words. I just said, I'm so terribly sorry. [Jenny]

If I'm insensitive or not paying attention, that is what they are going to remember about their family member's last days or last moments. Those moments are often imprinted in people's minds and I want that to be the very best situation it can possibly be. On our end I want to do everything to make it good. I want them to feel at peace about whatever is happening. [Maria]

### Theme Three: Moral Community

A *moral community* is a group of people working towards a common moral end. The nurses in this study indicated strong awareness of the importance of moral community and saw themselves as critical to the process of decision making regarding the withdrawal of aggressive treatment. For these nurses, the moral end sought was a good death for their patient. They thought it was important for physicians to share in the pursuit of this moral end. The nurses reported practices that recognized and positively utilized the relational nature of moral community. The specific practices they demonstrated relevant to moral community are (1) supporting relationships, (2) managing conflict, and (3) moral communicative work.

*Supporting relationships.* For the nurses in this study, relationships were central to getting their work done well. "Supporting" was a word used frequently as they described themselves, their roles, and responsibilities relative to forming and maintaining relationships that made a moral community possible. Recognizing the contributions of others to the care of the patient and family was a way to establish and preserve their moral community.

On patient and family support, one participant shared her perspective:

We always want to consider things through the patient; what the patient would decide for their self if they could. But they don't live in isolation; they live as part of this family. So I think this [supporting the family] is extremely important. [Fran]

Another shared her view on the importance of supporting her fellow nurses:

I want her to know I've got her back. There's nothing stupid she can say. I'm here for her. . . . I can't make everyone do things my way, and I wouldn't want that, because I don't think my way is always perfect. Wisdom is being able to

support, acknowledge, and give comfort to someone who is struggling or doubting what they said and feeling like they made a mistake and try to look at all the pieces to that and help them learn from it. **[Irene]**

Another shared the importance of supporting physicians:

I feel they [the family] deserve to hear a pretty good explanation from the physician, and then what I do is I let the physician take the lead, or I'll talk to the physicians and just say this is where we're at, and I'll just gently nudge them into that position. "Here you go, let me know when it's good for you to talk to this family." Then they do so, and what I do is support the physician. . . . I'll support the physician, and I feel that my role is to further educate them and answer their questions and concerns. **[Natalie]**

*Managing conflict.* In the complexity of health-care systems, conflict is inevitable, and this may be especially the case when the moral stakes are high. In spite of the inevitability of conflict, the nurses in this study did not view it as insurmountable and were skilled at staving it off or managing it to resolution. In the stories the nurses shared, the major underlying conflict was expressed as "Why are we doing this [aggressive treatment for a dying patient], and to what end?" This questioning directed the work of the moral community.

The nurse participants' narratives demonstrated their ability to recognize conflict, identify its source, minimize its impact, and manage the conflict to resolution. They continually worked to achieve and maintain positive relationships with families, physicians, and other team members. They saw communicative skill and patience as personal assets in conflict management. The conflicts were with families who did not want to acknowledge the deterioration and implications of the patient's condition, and with physicians who did not want to give up on aggressive treatment. The reasons for the conflict included differences in values between quality of life and quantity of life, the timing of withdrawal of treatment, and incongruent communication from different sources. Nurses described managing conflict as follows:

There are families who, if you try to talk to them about the reality of the illness, any deterioration, or anything that has to do with [the patient] not living, they just don't want to hear it. All they want to do is keep going no matter what, even though you have conversations with them

about quality of life. That gets difficult and they get angry. **[Bonnie]**

Usually the conflict is with the family or the physicians. A lot of times it is with the physicians. . . . I shouldn't stereotype, but sometimes they just don't want to let go. A lot of times they just want to avoid the issue. **[Elaine]**

The nurses shared examples of everyday practices that demonstrated their skill in minimizing impact and managing the conflict to resolution. Part of managing conflict is about understanding the reasons for actions and determining if they make sense. To achieve this, the nurses utilized the communicative skills of asking questions in an effort to understand the other person's perspective, and respectful listening. This communicative work enabled the nurses to protect and maintain relationships.

Situations of potential conflict, which are often the result of communication failure, were complicated by the common problem of families getting different information from different physicians. The nurses in this study were proactive in seeking resolutions by not being afraid to "speak up" regarding the problem and the need for resolution. A participant shared:

If the family expresses to me, "Gosh, we hear one thing from someone, one thing from someone else," I will tend to say, "I'm sorry. I'm going to get this clarified for you, so we can all get on the same page." Then I go straight to the physicians and say, "What's the plan? The family is confused. They are in a huge challenge." **[Jenny]**

Another study participant recognized that family members often need time to come to terms with the knowledge that their loved one is dying. She shared the value of patience in pro-actively managing potential conflict and "getting people on the same page":

How I deal with that basically is just to ask them why they feel the way they do and let them process it. Sometimes it takes two or three days for them to process. It's usually not just a process of "Okay, fine, yeah, we'll do that." It usually takes a while. We usually have a couple of conferences with the family, with the doctor, and bring in some other doctors, sometimes bringing palliative care into the conference. . . . I think the benefit from the conference is that everyone is together; everyone hears the same thing, and the doctors can answer the questions the family has. **[Elaine]**

*Moral communicative work.* A good death, one that is free from avoidable distress and suffering for patients, their families, and caregivers, is not possible without good communication. The nurses in this study demonstrated skill in moral communication: the verbal and nonverbal social interaction that enhances one another's understanding of the moral situations they are in and informs moral decision making and action. The nurses shared stories that demonstrated their skill in establishing rapport, preparing for conversations, asking questions, active listening, giving reflective feedback, being clear, and knowing when not to speak. The following quotes from participants in the study illustrate this work:

You start off with developing rapport. In the ICU, you have to do it quickly. If you develop rapport within the first few minutes of meeting somebody, it holds for the shift. You need to be able to build that trust right away. So you start with the family members, feel them out to see where they're at. "How are you doing with all this? Is there anything you'd like to talk about? What have the doctors been telling you about how things have been going?" . . . Then summarizing for them where the patient's at currently, like, "The patient came in really sick. This is what we're seeing right now," gently telling them the information. [Pam]

Wise nurses are good listeners, and they do more listening than speaking. Sometimes you can intervene without saying anything. Sometimes by being a good listener, the person all of a sudden comes up with a discovery of what they were looking for because they either see it in your face or they heard themselves say it out loud, and suddenly it opens a door to something else they think about. I see that quite frequently. Sometimes that is wisdom, knowing when to let someone make a discovery for him- or herself. [Irene]

## DISCUSSION

This study extends the nursing literature on moral distress by reversing the focus from the causes and implications for critical care nurses to the reported practices of those who do not appear to experience its damaging effects. Although not asked directly about moral distress, the nurses in this study—who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment—did not show evidence of experiencing moral distress in the midst of commonly distressing situations. These nurse par-

ticipants reported practices that appear to function as safeguards against its negative consequences. The narrative analysis of the stories they shared illustrates that experienced critical care nurses working with dying patients can navigate around or through distressing situations without the consequent moral distress by enacting moral agency, exercising moral imagination, and fostering moral community.

### Moral Agency

The first antidote for critical care nurses' moral distress is *moral agency*. The nursing literature speaks much of empowerment, but little of moral agency. Yet nurses *are* moral agents; they must have agency in order to influence relationships and outcomes in their workplace. We argue for replacing the concept and language of "empowerment" with that of "moral agency."

The concepts of empowerment and moral agency are not unrelated. However, empowerment implies authorization or permission to act, whereas agency implies self-directed capacity or choice to act. Clearly this difference has moral significance. The nurses in this study did not need to have their actions authorized or legitimated by others—they took responsibility and held themselves accountable and did not fail to act because of either external or internal constraints.

The critical care environment for this study did not appear to be unlike other ICUs where nurses have reported experiencing moral distress. Yet, the causes of moral distress reported in the literature were either not expressed or were overcome by the study nurses. For example, a frequent source of moral distress for critical care nurses that is cited in the literature is a lack of input on end-of-life decision making. The nurses in this study saw themselves as active moral agents with not just a key role, but in fact a responsibility to facilitate end-of-life discussions. They demonstrated skill in moral communication, the verbal and nonverbal social interaction that enhances understanding of moral situations, informs moral decision making, and facilitates moral action. They worked to establish and maintain moral communities, asserting themselves as essential to the process of decision making regarding the withdrawal of aggressive treatment and the actions necessary to foster a "good death," the moral end sought. (The nurses' descriptions of their work contributing to a "good death" was consistent with Marilyn J. Field and Christine K. Cassell's definition as "one that is free from avoidable distress and suffering for the patients, families and caregivers; in general accord with the patients' and families' wishes; and

reasonably consistent with clinical cultural and ethical standards.”<sup>28</sup>)

The nurse participants in this study shared common characteristics of what we have termed “accountability for self,” a component of self-awareness. The study findings demonstrate the relationship between self-awareness and what the feminist philosophical literature describes as moral identity. For Margaret Urban Walker, moral identity is an accounting of what a person takes responsibility for, responds to, is concerned about, cares for, and values—this *is* moral agency.<sup>29</sup>

The other component of self-awareness we termed “accounting for skill.” The nurses in this study were adept at this. Many attributed their skill to longevity in their position and unit and learning from repeated experiences, which they also shared with one another. Previous studies have reported correlations between years of experience and moral distress, but the findings are inconclusive.<sup>30</sup> In a 2005 study of critical care nurses, Ellen H. Elpern and colleagues found that intensity of moral distress increased with years of nursing experience.<sup>31</sup> This led the authors to speculate that with increasing years in the profession the cumulative effect of distressing experiences increased as well. On the other hand, Katherine A. Hinderer found that increased years of experience with patients’ deaths was a major element in critical care nurses’ coping skill.<sup>32</sup> Our study confirms Hinderer’s findings. We believe this is because the nurses were able to form and sustain moral communities, another antidote to moral distress that is discussed further below.

### Moral Imagination

The second antidote to moral distress in critical care nurses is *moral imagination*. Moral imagination requires not just the skill of being able to imagine various possibilities and their consequences, but the ability to morally evaluate the possibilities as well. This is not a new concept. P. Anne Scott defined moral imagination as “that aspect of the imagination that potentially becomes active in the moral agent’s attempt to consider what moral decisions to make.”<sup>33</sup> Mary C. Corley, drawing on Scott’s work, argued that nurses who have an acute moral imagination are more likely to have a high level of moral sensitivity and moral competence, and experience less moral distress.<sup>34</sup> This study supports Corley’s work and adds the specific practices by which moral imagination is demonstrated. These practices include empathy, ascertaining what the patient would want, and envisioning and facilitating moral possibilities for a good death.

Knowing the patient was absolutely critical to these nurses. Having empathy for the embodied suffering of the patient and knowing the biographical life of the patient were the ways they ascertained what the patient would want by helping families answer the question, “Would your loved one want to live *like this*?” When families can see the biographical life of their loved one being respected and honored by the transition from aggressive treatment to comfort care, the likelihood of a good death—the moral end that is sought—is made possible.

### Moral Community

Fostering *moral community* is the third antidote to the moral distress experienced by critical care nurses. A moral community is a group of people united by a shared common end with moral implications: in this case, the well-being of patients. Working for the well-being of patients by many people and groups requires sustained coordination of action across these people and groups. Relationships that allow for questioning, that can tolerate the expression of uncertainty, and that are frequently accompanied by strong affect are essential to coordinating this work. Recognizing the contribution of others and being able to call attention when these things are lacking reinforces the goal of the work and minimizes disruption of the work. The nurses in this study were expert in supporting relationships that foster a moral community.

It is important to note that communities typically reflect multiple ends, at least some of which will inevitably conflict. For this reason, managing conflict is an essential skill for working in a complex social world. Differing perspectives regarding end-of-life care are a major cause of conflict and moral distress in critical care nurses. The practice of managing conflict is intertwined with being a skilled communicator. A study that examined family members’ responses to making choices regarding the withdrawal of aggressive treatment found that conflict was the result of their unmet needs for information and communication.<sup>35</sup> The data suggest that a shift from aggressive treatment to comfort care was often perceived by patients’ family members as abrupt and unexplained, and contributed to conflict. The narratives shared by the nurses in this study support that finding. However, the study nurses utilized the communicative skill of asking questions and respectful listening in an effort to understand family members’ perspectives and needs in the face of decision making regarding the withdrawal of aggressive treatment, thereby minimizing the potential for conflict.

A study that described the stressors experienced by critical care nurses in providing end-of-life care found that professional stressors included difficulty in collaborating with physicians as well as difficulty in communicating with families.<sup>36</sup> The practice of moral communicative work is not only important to offsetting these stressors, it underlies every other specific practice previously discussed.

Feminist healthcare ethics recognizes the work of nurses as embedded in complex social networks including healthcare providers, patients, families, administrators, and others further organized under political and economic structures.<sup>37</sup> Historically, these networks have been structured in strict hierarchies that are marked by differences in power and knowledge. Today the emphasis is on teamwork in an attempt to reduce these hierarchical differences and recognize the contributions of all involved in patient care. As laudable as this effort is, we argue that the notion of a team and of teamwork lacks the moral connotation that health work deserves. The notion that healthcare environments are moral communities rather than hierarchical organizations has been increasingly recognized as imperative to good patient care and end-of-life decision making.<sup>38</sup> In terms of moral distress, this is particularly important in caring for the dying. We argue for replacing the concept and language of “teamwork” with that of “moral community.”

### LIMITATIONS

The study was limited because the practices identified were based on the participants’ self-reporting rather than observed, real-time behavior. It was also limited by the participants’ self-selection and lack of diversity. The study group was all female, with an average age of 48 years. The findings are not necessarily reflective of the demographics of a larger, more diverse ICU. Further, the study was limited to one midwestern teaching hospital in a major city.

### CONCLUSION

As medical technology continues to expand our capability to prolong life, extending the dying process is a potential complication. The line between too little and too much treatment is increasingly blurred. Continued attention to the consequent moral distress is necessary. Healthcare moral communities can benefit from the knowledge gleaned from this study and its implications for reducing moral distress in critical care nurses.

Given that few nurses in this study had formal education regarding death and dying, we believe their education had little impact on their ability to navigate around or through morally distressing situations. These nurses spoke a great deal of supporting each other and supporting newer nurses. This speaks to the value of mentorship.

A feminist moral perspective contributes two important insights. One is that moral issues do not stand outside of their social contexts. The problems of morality are embedded in everyday work. The second insight is that humans are intrinsically relational and interdependent, which emphasizes the significance of connection, sharing, and community.<sup>39</sup> A feminist lens supports a shift in thinking and language away from empowerment toward moral agency and from teamwork toward moral community. The advantage of this language is to highlight the morality that is embedded in day-to-day nursing work and the ways in which nurses understand their moral identity, relationships, responsibilities, and values.<sup>40</sup>

The findings of this study are valuable in providing illumination and exemplars for what expert practice in caring for patients who are transitioning from aggressive treatment to comfort care actually looks like. Because these practices are identifiable, we assume they are replicable. We suggest that interventions that are designed to mitigate moral distress use these concepts and language. The development of critical care nurses who are able to navigate around or through morally distressing situations can be achieved through mentorship in moral agency, moral imagination, and the fostering of moral communities.

### CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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### NOTES

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