MORAL AGENCY AND MORAL DISTRESS AMONG REGISTERED NURSES:
NOVICE TO EXPERT

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By

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Elisabeth Pauline Fortier, candidate for the degree of Master of Science in Kinesiology & Health Studies, has presented a thesis titled, *Moral Agency and Moral Distress Among Registered Nurses: Novice to Expert*, in an oral examination held on July 31, 2018. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

In everyday practice, nurses encounter moral dilemmas that can potentially impact patients’ quality of care. A nurse exercising moral agency makes ethical decisions based on core values and moral principles. Moral agency has roots in existential philosophy; it can significantly impact the organizational role of nurses, the healthcare system, and patients. The relationship between a moral agent and the institution in which they practice has been labeled the most challenging moral problem of our century. Moral distress can be precipitated by a diminished sense of moral agency. Understanding moral agency in a bureaucratic system like healthcare is necessary to comprehend ethical issues and moral distress experienced by nurses.

In this thesis, I, the researcher, explored moral agency and moral distress as experienced by twenty registered nurses (RNs). The distinctions between Novice and Expert RNs were based on years of experience and the work of Benner (1984). Participants were recruited using purposive sampling and a modified snowball sampling technique and face to face interviews were subsequently conducted. De Groot’s methodology (1964) was used as a framework for the study, interviews as the method of data collection and thematic content analysis was used to analyze data. Findings reveal the organizational factors (understaffing, heavy workloads, and time) limiting nurses’ moral agency and potentially leading to moral distress. The three major themes are “Organizational Context: Factors impeding Moral Agency and leading to Moral Distress among RNs”, “Growth of Moral Agency: How RNs develop voice”, and “Moral Agency and Moral Distress in End of life Care”. The themes also touch on the differences and similarities between Novice and Expert RNs as I anticipated differences based on the work of Benner (1984). This
distinction was important as I suggest moral distress and moral agency may be different based on experience. The study suggests RNs strive to be moral agents, but often face limitations in exercising moral agency in their profession. This research makes an original contribution to knowledge in the field of healthcare ethics as it is the first study of its kind on moral agency and moral distress among RNs in Canada.

*Keywords*: Moral agency, moral distress, registered nurses, healthcare, bureaucracy
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Dedication

*In the end, it all happened because of a broken system.* (Nurse 11)

Dedicated to the 20 nurses who participated in this thesis. In a healthcare system often described as *broken*, your sacrifice and courage are overwhelming. Thank you for your commitment to the fundamental values of nursing. Your voices as nurses brings hope to our community.
# Table of Contents

Abstract ................................................................................................................................. i  
Acknowledgements ............................................................................................................... iii  
Dedication ............................................................................................................................... iv  
Table of Contents .................................................................................................................. v  
List of Tables ........................................................................................................................ vii  
List of Appendices ................................................................................................................ viii  

## CHAPTER ONE: Introduction ......................................................................................... 1  
1.1 Reflection ......................................................................................................................... 1  
1.2 Nursing in Canada ........................................................................................................... 3  
1.3 Novice to Expert ............................................................................................................. 6  
1.4 Definition of Concepts ................................................................................................. 8  
1.4 Purpose & Research Questions ..................................................................................... 9  

## CHAPTER TWO: Review of Literature ............................................................................. 10  
2.1 Why Philosophy? ............................................................................................................ 10  
2.2 Existentialism ................................................................................................................ 11  
2.3 Moral Distress ............................................................................................................... 18  
2.4 Moral Resilience .......................................................................................................... 21  
2.4.1 Meaningful Work and Hardiness. ........................................................................... 23  
2.5 Bureaucracy .................................................................................................................. 24  
2.5.1 Organizational Culture. ......................................................................................... 26  

## CHAPTER THREE: Methodology ..................................................................................... 30  
3.1 Epistemology .................................................................................................................. 30  
3.1.1 De Groot’s Methodology ....................................................................................... 31  
3.2 Methods ......................................................................................................................... 33  
3.2.1 Sampling Overview. ............................................................................................. 34  
3.2.2 Sample Characteristics.......................................................................................... 34  
3.2.3 Sampling Method & Recruitment ......................................................................... 34  
3.2.5 Consent & Confidentiality Agreement. ................................................................. 35
3.2.6 Data Collection .................................................................................................................. 36
3.2.7 Data Analysis .................................................................................................................... 37
3.3 Trustworthiness ................................................................................................................... 40
3.4. Potential Limitations ......................................................................................................... 40

CHAPTER FOUR: Findings ........................................................................................................ 42
4.1 Overview of Findings .......................................................................................................... 43
4.2 Theme 1: Organizational Context: Factors impeding Moral Agency and leading to Moral Distress among RNs ............................................................... 47
  4.2.1 Staffing, Workloads & Time: Novice RNs, Moral Agency & Moral Distress. 48
  4.2.2 Staffing, Workloads & Time: Expert RNs “Keep going”. ......................... 54
  4.2.3 Novice RN’s Perceptions of Administration ......................................................... 60
  4.2.4 Expert RNs’ Perceptions of Administration ......................................................... 64
4.3 Theme 2: Growth of Moral Agency: How RNs develop voice ......................... 67
  4.3.1 Novice RNs’ Voices in a Bureaucratic System ....................................................... 67
  4.3.2 Expert RNs’ Voices in a Bureaucratic System ....................................................... 70
4.4 Theme 3: Moral Agency and Moral Distress in End of life Care ................... 80
  4.4.1 Moral Agency and Moral Distress in End of life Care: Novice RNs. .......... 80
  4.4.2 Moral Agency and Moral Distress in End of life Care: Expert RNs. .......... 84
4.5 Conclusion of Findings ....................................................................................................... 94

CHAPTER FIVE: Discussion ..................................................................................................... 95
5.1 Organizational culture in healthcare ................................................................................. 96
  5.1.1 Perceptions of administration .................................................................................... 98
5.2 Moral Agency and CNA’s Code of Ethics ........................................................................ 100
5.3 From Novice to Expert to Now ....................................................................................... 101
5.4 Implications with End of life Care .................................................................................. 105
5.5 Recommendations ........................................................................................................... 107

CHAPTER SIX: Conclusion ................................................................................................... 110
References .............................................................................................................................. 112
List of Tables

Themes ........................................................................................................................................ 43
Model Representing Findings ........................................................................................................ 46
List of Appendices

Appendix A: Participants’ Characteristics ..........................................................129
Appendix B: Initial Letter of Contact .................................................................130
Appendix C: Consent & Confidentiality Form ....................................................131
Appendix D: University of Research Ethics Board Approval .............................134
Appendix E: Interview Questions ......................................................................135
CHAPTER ONE: Introduction

1.1 Reflection

When I first began researching the topic of moral agency and moral distress among nurses three years ago, I had a basic understanding of the healthcare system. I knew nurses encountered barriers such as understaffing, but I assumed this could be resolved by hiring more nurses. However, it is not that simple. I learned through this research, that the healthcare system is extremely complex. The ethical and moral issues created by organizational constraints do not have straightforward solutions. At the start of the research, I did not comprehend the influence bureaucratic factors have on care provided to patients or how it impacts nurses. Having not had any significant health issues before conducting this research, I had limited exposure to the healthcare system. I believe having this openness helped me engage with the nurses’ stories and accept the meaning they ascribed to their experiences.

Through the qualitative process, I kept a reflexive journal in which I wrote down my thoughts throughout the data collection and the data analysis. I often questioned why the healthcare system appears to be so broken. I found the data collection and data analysis process to be difficult as the stories told by nurses were troubling and often traumatic. I remember one day this past summer, I conducted four interviews in one day. I came home that night incredibly sad and upset at our health care system. I asked myself; does every nurse suffer like this? Why do patients fall through the cracks? What are the solutions? I had no answers, or trust in the system.

I discovered that the human side of the healthcare system can be understood through the qualitative approach. Through hearing the stories of nurses, I became aware
of their pain and suffering, but also of their concern for patients. I empathized with them by attempting to put myself in their shoes. This winter, I experienced being a patient in the healthcare system. It was shocking to me, to see physician after physician, month after month until I finally helped myself by finding out the most likely cause of my symptoms. When seeing physicians, I felt rushed and the need to constantly advocate for myself. This is something that nurses told me patients need to do more and more. It appeared to me that the system was filled with inefficiencies. For example, I waited 1.5 hours for a scheduled appointment that ended up lasting 2 minutes. However, being admitted for a minor surgery in June helped me put my trust back in the healthcare system. Even though I had waited numerous months for this surgery, I had a wonderful experience in the hospital. The physicians and nurses were both professional and empathetic. The nurses were busy, but they took the time to reassure me, answered all my questions, and also shared with me some of their experiences of working in the healthcare system. One of my nurses had 46 years of experience, she anecdotally described how the system has changed. My other nurse was an Expert in Palliative care, she told me not to worry, she would make sure my pain was manageable. I was so thankful for these nurses, they gave me their best; their most heartfelt compassion.

Overall, hearing the voices of nurses through this research, impacted me on a personal level by enlightening me to see the condition of human suffering. Through my reflexive journal, I questioned; why should we be concerned about the suffering illustrated through the nurses’ stories? The answer, for once, is straightforward; it is because silence increases suffering, creates distress and ultimately impacts patient care. When we remain
silent about the realities of nurses and patients we diminish their experiences. Acknowledging the pain and suffering in the system can help us all overcome it.

1.2 Nursing in Canada

In Canada, there are more than 300,000 registered nurses working on the frontline of the healthcare system (Canadian Nurses Association, 2009; Canadian Institute for Health Information [CIHI], 2018). The care they provide reduces costs to the health system and improves health outcomes in patients (Canadian Nurses Association, 2009). In providing assessments and intervening in care, nurses improve quality of health services (Canadian Nurses Association, 2009; CIHI, 2018). McGillis, Hall, Doran, and Pink (2004) found that having more registered nurses on surgical units leads to lower levels of medication errors and injury infections. Further, nurses increase access to the health system and decrease wait times by coordinating care and helping patients navigate the system (Canadian Nurses Association, 2009; CIHI, 2018). Significant evidence indicates that in-patient deaths can be avoided by increasing nurses’ hours of care (Dall, Chen, Seifert, Maddox, & Hogan, 2009; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Kane et al., 2007; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006; Person et al., 2004). Additionally, increasing hours of care leads to cost saving through reduced hospital stays and negative health outcomes (Needleman et al., 2006). Nurses represent an investment for the health system as they provide quality care, aid in reducing the length of hospital stay, and the number of readmissions (Canadian Nurses Association, 2009; CIHI, 2018).
Further, O’Brien and colleagues (2008) found a link between turnover and decreased job satisfaction, the probability of medical errors, and increased overtime hours. They found that every year, one in five nurses abandon the profession in Canadian hospitals. Nurses with higher satisfaction levels in regards to work autonomy are more likely to remain in the profession (Stewart et al., 2011). Shields and Wilkins (2006) analyzed the 2005 National Survey of the Work and Health of Nurses. They suggest that over a year, time lost because of illness and injury corresponds to the hours worked by 15 thousand registered nurses. Therefore, if health-related absenteeism was decreased by half, the health system could save 500 million dollars in incomes alone. According to the Canadian Nurses Association, reducing absenteeism will improve productivity and decrease costs (2009).

Additionally, it is important to note that the cost of replacing nurses is high financially and limits organizational productivity (Beercroft et al., 2001; Lindsey & Kleiner, 2005). Nurses may leave the profession feeling overworked, unprepared, and fatigued. Lyndon (2007) identified fatigue to negatively impact patients since it decreases health professionals’ judgment, raises the risk of errors, poor communication, and lack of stability in care. The Canadian Nurses’ Association (2012) also supports that fatigue leads to moral distress through impaired physical and mental health. It also notes that health care cultures produce pressures for nurses to assume additional workloads causing increased fatigue. The statistics above are concerning for the sustainability of healthcare and the well-being of nurses.
The implications for the cost-effectiveness of reduced turnover, absenteeism, and fatigue are significant for the health system. Some suggest the market best distributes care as it supports institutional goals of efficiency, effectiveness, and productivity (Tronto, 2010). Rodney and Street (2004), assert that privileging corporatism and efficiency in healthcare institutions leads to the commodification of care and conflicts with nurses’ identities. Peter and Liaschenko (2016), support this when stating; “Corporatism has resulted in the subordination of patient care goals to institutional goals, resulting in the erosion of the value of care” (p. 19). The commodification of care is not individually focused and does not take into account diverse patient needs (Tronto, 2010). Privileging corporatism favours short-term economic imperatives rather than encouraging the caring component of nursing which may have long term benefits (Peter & Liaschenko, 2013). Consequently, preserving nurses’ caring identity is a constant challenge as agency and identity can conflict with overarching goals of structured institutions like healthcare (Peter & Liaschenko, 2013).

Cribb (2011) suggests that such evolving trends exhibit market economy and market-oriented society. This appears to compromise the professional values of nurses, thus reshaping health care values and its priorities. The moral agency of nurses is at risk when hospitals value a market-oriented healthcare culture over the caring paradigm of their profession. Organizational goals of efficiency and effectiveness lead to impersonality, dispensability, and value-neutrality (Simon, 1976; Weber, 1947). Potentially, an overemphasis on efficiency minimizes autonomy and negatively impacts moral agency. When nurses juggle conflicting loyalties between patient care and the
system’s goal, it can also lead to moral distress (Rodney, 2017; Liaschenko, & Peter, 2016; Raines, 1994).

To understand the importance of moral agency and the impact of moral distress in the organizational context in which nurses’ work, it is important to learn about their experiences at different stages of their career; “the complexity and responsibility of nursing practice today requires…an understanding of the differences between the experienced nurse and the novice” (Benner, 1982, p. 402). Nurses entering the workforce encounter a tension between the bureaucratic values seen in the healthcare practice context and the fundamental values of nursing (Price & Reichert, 2017). Exploring the Novice and Expert perspectives has the potential to guide us in learning about how organizational factors impact nurses, how to increase moral agency, and how to decrease moral distress.

1.3 Novice to Expert

In 1984, Benner, wrote From Novice to Expert, where she revealed the levels of proficiency of 51 experienced nurses, 11 new graduate nurses and five senior nursing students in various nursing settings. Benner (1984) suggested that a Novice nurse has between 0 to five years of clinical experience and an Expert has over five years. She explains that experience is more than the passage of time. It also considers the quality and the context of the experiences. In 1984, Benner perceived the Novice to Expert journey as linear, however, it appears no longer this way in the current system.

According to Benner (1984) Novice nurses begin their careers with little understanding of the context they work in and of the bigger picture. Everything is unfamiliar; therefore, they need support in setting priorities. After gaining experience for two to three years, Benner (1984) suggests nurses start to reveal competence by following
rules, plans, and beginning to see their actions as part of the system. Nonetheless, Novice nurses still lack the speed and flexibility of Expert nurses. Seeing their actions as part of a larger goal helps the RN develop the ability to prioritize.

At the Expert level, nurses follow their intuition to guide practice rather than abstract rules. Benner (1984), suggests that if Experts had to act based on formal rules or guidelines their performance would deteriorate. For Expert RNs, rules have been integrated through understanding the fundamental ways of knowing.

Further, to understand the moral agency of Expert nurses, it is important to understand the fundamental ways of knowing. Carper (1978), explained the four areas of knowledge and beliefs in professional nursing practice. First, through their studies nurses acquire empirical knowledge, then through their practice they derive knowledge from personal understanding and empathy towards patients (Carper, 1978). At the ethical level are nurses’ attitudes and values. They have an awareness to moral questions, choices and responsibility. Finally, the aesthetic level, relates to the here and now. It is at this level of knowledge that nurses integrate the various levels of knowledge. They understand immediate situations and practical action, they are aware of their patients, and their circumstances. This level encompasses the beauty of nursing as the nurses’ actions and behaviour flow naturally and appear effortless. Expert nurses often demonstrate these fundamental ways of knowing and it provides a guide to holistic practice.
1.4 Definition of Concepts

Before delving into the literature review it is important to provide definitions of key concepts discussed in this thesis; moral distress and moral agency. Moral distress occurs when nurses are unable to act according to their moral perceptions. They feel they know the right course of action to take but cannot follow through because of system structures or internal factors such as personal values (Jameton, 1984).

Moral agency encompasses responsibility, freedom, and choice in ethical decision making. Being a moral agent means having the ability to recognize ethical issues, and have a willingness to act on this recognition (Raines, 1994). A historical look at literature concerning nurses’ relationship with institutions reveals that the moral agency of nurses is often limited (Yarling & McElmurry, 1986). This discovery was attributed to Davis and Aroskar (1978) who questioned the influence of hospitals on nurses’ moral expression by discussing the implicit confronting loyalties between patients, physicians, and institutions. This was later confirmed by Raines (1994) who stated that “as nurses become imbued with the organization’s mission and purpose, they develop loyalty to the institution. . .” (p. 6). Recently, Liaschenko and Peter (2016) have argued that the relationship between a moral agent and the organization in which they practice may be “the most challenging moral problem of the twenty-first century. . .” (p. 18). An understanding of moral agency in a bureaucracy such as the healthcare system is needed to comprehend the moral issues encountered by nurses in their professional practice.
1.4 Purpose & Research Questions

The purpose of this research was to explore moral agency and moral distress among Novice and Expert registered nurses as well as the impact of bureaucratic factors.

1) What organizational factors impact moral agency and contribute to moral distress?

2) What are the differences and similarities between the moral agency of Novice and Expert registered nurses?
CHAPTER TWO: Review of Literature

When, I, the researcher, began this thesis, there were few studies directly looking at moral agency in nursing. Most of the literature framed moral agency and moral distress together and very few mentioned organizational context. Through this literature review the reader will notice a balance between a focus on each concept and its link to other concepts in the context of the healthcare system. The studies and books mentioned below were selected by searching for key words in scholarly journals and search engines. I used words such as moral agency, nursing, and moral distress to find relevant literature. A snowball effect followed as studies opened the doors to others through their references and citations. Overall, this thesis is grounded both in theory and recent works, while citing key authors’ works consistently.

2.1 Why Philosophy?

Why should philosophy be applied to health systems? It can give health professionals the power to become authentic decision makers (Malloy & Lang, 2016). As described by Malloy and Lang (2016), philosophy is a tool that can help everyone think through everyday issues. Applying philosophy to health systems gives health professionals meaningful ways to comprehend morality and ethics in everyday practice. Through philosophy, employees can question and reach a sense of meaning in their work (Malloy & Lang, 2016). For instance, existential philosophy can be used to frame ethical decision making in healthcare. Through existential thought, nurses acknowledge their personal freedom, choice, and responsibility (Malloy & Lang, 2016). These three core principles of existentialism allow for authentic decision making and awareness of moral and ethical challenges. Applied philosophy in health systems can empower nurses to be authentic
agents and effective leaders in their professional practice. Applying philosophy to healthcare may add to the long-term effectiveness of health organizations and improve sustainability by allowing nurses to use core values in their work. To become authentic in healthcare, one must understand the culture of the system as it relates to the power of nurses’ voices. Existential philosophy can help agents of an organization (nurses) to understand how to be authentic in bureaucracies such as health systems.

2.2 Existentialism

A significant contributor to existential thought was Jean-Paul Sartre, who asserted that we represent our choices. This means as we exercise free will; we become the sum of our decisions (Agarwal & Malloy 2000). Sartre suggests that decisions represent how we create ourselves. Our identities are not predestined but formed through freedom, choice, and responsibility (Sartre, 1985). It is our responsibility, as humans, to discover the meaning of our existence. This core principle allows us to accept the freedom to create our essence. In discovering what it means to be human, we can consciously be authentic and adopt core values.

Existentialism explains that having an awareness to authenticity allows individuals to be mindful decision makers and have a stronger understanding of responsibility in their personal and professional lives (Guignon, 1986). As confirmed by Agarwal and Malloy (2000), the authentic relationship between the individual and their professional role as decision maker enables commitment and awareness to organizational values and goals. Existential thought plays an important role in the professional life of an individual working in a bureaucracy. If they blindly accept duty or an institution’s values, they act in bad faith.
In contrast, Sartre’s concept of authenticity originates from good faith, which recognizes inborn freedom (1985) and can be demonstrated through internalizing one’s professional role. Acting in good faith can be used interchangeably with moral agency as the ability to make moral decisions, judgments, and be accountable. Individuals working in bureaucratic institutions can authentically relinquish some aspects of their freedom in good faith by being aware that they are doing so. For instance, in healthcare, a nurse is a person first choosing to undertake a professional role to care for patients. This role may constitute the essence of this person’s life. Accepting a professional role allows them to be authentic and find meaning in their work. Thus, relinquishing some freedom does not signify surrendering one’s agency. Rather, it requires one to exercise it by choosing. In taking a conscious decision, an individual is taking a *leap of faith*, an existential metaphor, representing an “individual stand[ing] at the edge of the decision abyss armed with the available knowledge of the best ends and the best means. . .” (Agarwal & Malloy, 2000, p. 152). The leap occurs when the individual decision maker chooses authentically. Nonetheless, Garofalo and Geurus (2005) state

> We must not too hastily suppose that an organizational failure of moral agency necessarily entails that specific members of the agency are weak moral agents. Often, the sheer weight of an organization’s size, complexity, and inertia overwhelms even the best-motivated members, including managers. (p. 40)

While the intensity of bureaucratic environments seems to influence individual action, the quotation above does not align with existential thought. In reality, it promotes acting in bad faith by shifting individual responsibility onto the organization. Thus, “weak moral agents” inauthentically disown personal accountability by blindly accepting organizational values. Further, the assumption that avoidance in choosing an action leads one to be relieved of accountability is untrue (Raines, 1994). If an individual chooses to
reject freedom, it leads to inauthentic living. Existential freedom is inescapable as individuals who avoid choice are still choosing (Sartre, 1985). This is why existentialists call it a “terrible freedom,” full of anguish experienced because of the acknowledgment of responsibility in choice regardless of the outcome (Agarwal & Malloy 2000). Kierkegaard described individuals’ inclination to hide behind others or policy to avoid responsibility (Agarwal & Malloy 2000). Liedtka (1989) suggests that existentialism in institutions appears as a culture and climate nurturing opportunity for choice, creativity, and accountability. Further, existential philosophy in organizations would be a place where individual authentic goals and values correspond to the organization’s goals and values (Liedtka, 1989). According to Guignon (1986), this perspective on decision making can be intimidating for organizations as it signifies encouraging individuals to be authentic and to think and act according to personal values rather than the organizations’. While organizational behaviour encourages conformity (Sinclair, 1993), it may also lead to a feeling of dissonance with one’s role (Hodgkinson 1996; Werhance 1999). Fostering existential freedom may allow individuals to be authentically committed employees in cognitive and moral consonance with the organization (Hodgkinson 1996; Werhance 1999).

Existentialism at its core is a decision-making philosophy centered on choice and the anxiety in accepting freedom and responsibility (Agarwal & Malloy, 2000). The existential perspective can have a significant part in the organizational role of nurses, the healthcare system, and patients, who are impacted by the “individual-organizational moral conduct” (Agarwal & Malloy, 2000, p.153). A moral agent understands the responsibility in their freedom, have the ability to recognize issues, and have a willingness to act (Raines,
1994). Authentic individuals overcome and navigate through bureaucracies by using their moral agency.

2.2.1 Moral agency in healthcare.

The concept of moral agency offers an uplifting perspective to ethical decision-making within the nursing profession (Raines, 1994). It provides insight into “how nurses choose to act when faced with a choice among conflicting values and principles” (Raines, 1994, p. 5). Moral agency is expressed through the process of decision making. Ethical dilemmas are the catalyst to expressions of moral agency as they generate a choice “involv[ing] a breach of one’s responsibility to another person, principle, or value” (Raines, 1994, p. 8). Through diverging loyalties, nurses’ moral decision making is influenced by organizational factors and individual worldviews (Davis, 1989). Rodney et al. (2013) further describe moral agency as “rational and self-expressive choice, embodiment, identity, social and historical relational influences, and autonomous action within wider social structures” (p. 163). This signifies that in healthcare, the outcomes of moral agency have implications for the social structure and organizational culture of the system as well as direct influence on nurse and patients (Raines, 1994).

The primary focus of nursing ethics are the moral decisions facing nurses in everyday duties, interactions, and reflections (Canadian Nurse Association’s Code of Ethics- CNACE, 2008). However, literature provides little insight into nurse’s daily moral choices. There is also limited knowledge on the process and extent of moral agency in healthcare.

Moral agency is crucial as it leads nurses to become aware of ethical dilemmas by acknowledging personal freedom, choice, and responsibility. It may also offer clarity
in moral uncertainty, a term describing a nurses’ feelings of indecision or inability “to know what the moral problem is, while [simultaneously] feeling uneasy” (CNACE, 2008, p. 6). Moral agency is necessary to affirm one’s moral principles and allows for the expression of one’s ethical voice.

It is important to understand how moral agency occurs. According to Raines (1994), moral agency is enacted under conditions specific to individual traits. Moral agency exists with certain characteristics such as privileged relationships (between the nurse and patient), duty, courage and a willingness to act (Raines, 1994). At times, being a moral agent may even signify going against culture, authority, tradition, and current standards (Raines, 1994). However, when those conditions are not met, they become barriers to moral agency in nursing; “because of the routine, task-oriented nature of the job, a privileged relationship is not established” (Raines, 1994, p. 7). In its practical application, moral agency occurs in social structures such as healthcare institutions. For individuals to be moral agents, their environment must facilitate the enactment of decisions (Raines, 1994). However, institutional constraints may implicitly overwhelm and limit the moral agency of nurses. After studying 167 nurses, Mayberry (1986) suggested that work environment factors like policies and organizational structures influence one’s moral reasoning. Further, Penticuff (1989) remarked that contextual factors influence moral behaviour such as the impact of administration, limited resources and nursing turnover rates. While organizational goals may increase efficiency and effectiveness, these factors can be the source of ethical problems and limit the optimal expression of moral agency.

Health organizations are complex social institutions (Liaschenko & Peter, 2016) with productivity objectives. To provide patient care within this context, nurses apply
technical skills and adhere to bureaucratic ideals. However, these goals may constrain nurses by conflicting with the moral or holistic well-being of patients (Liaschenko & Peter, 2016). Moral distress can be triggered by a diminished sense of moral agency (Epstein & Delgado, 2010; McCarthy & Gastman, 2015). When approaching questions of values and choice, moral agency allows nurses to embrace the caring components of nursing by focusing on needs of patients (Raines, 1994).

The Canadian Nurses Association discusses the importance of moral responsibility in its 2008 Code of Ethics (which was updated in 2017, See Chapter 5). It affirms that; “Nurses need to recognize that they are moral agents in providing care” (p. 5). This highlights the responsibility and accountability assumed by nurses to act ethically through choices and behaviours. To accomplish this, Liaschenko and Peter (2016) explain that nurses should express deliberate power to develop a strong presence within healthcare’s moral discourse. In an international study on the perceptions of the effectiveness of ethical guidelines in physicians, Malloy and colleagues (2009) found that codes of ethics were valued only when they aligned with existing personal morality. Tadd and colleagues (2006) had looked at this phenomenon among nurses and had also suggested “most participants had a poor understanding of their codes…[they] believed they have little practical value because of extensive barriers to their effective use” (p. 376).

Nurses’ feelings of being silenced or voiceless during morally multifaceted situations in healthcare can lead to a sense of being powerless (Epstein & Delgado, 2010). This impedes on nurses’ ability to bring one’s perspective to the conversation (Epstein & Delgado, 2010). In the context of patient care, Liaschenko (2008) suggests that nurses should be able to say to other health professionals that; “I am holding you morally
accountable to take my concerns seriously because my part in the care of this patient is just as important as your part” (p. 197). This conception of power emphasizes one’s ability to have a voice and be respected. Although unrealistic, this quote explicitly demonstrates moral agency and nurtures the moral identity of nurses to be moral agents. Having the courage to express moral agency reinforces values of responsibility and accountability defined in the 2008 CNACE. However, the responsibility of the CNACE is to create policies to foster moral agency in healthcare. Creating a place for moral agency among nurses in healthcare may improve nurses’ perceptions of power, improve their position within the profession’s social context, and alter organizational culture to highlight the caring components of nursing.

2.2.3 Deconstructing Moral Agency.

The previous sections on existentialism and moral agency can be summarized by deconstructing the following definition by Canadian Nurse Association’s Code of Ethics: “The capacity or power of a nurse to direct his or her motives and actions to some ethical end; essentially, doing what is good and right” (CNACE, 2008, p. 6).

This definition of moral agency seems incomplete when looking at literature through an existentialist lens. The conceptualization of moral agency by the CNACE implies that what is good and right for one is universally good for all. While it is true that individuals should act with humanity in mind as suggested by philosopher Jean-Paul Sartre (1985), moral agency does not distinguish between right and wrong. It does not tell people what they ought to do, how to behave, nor does it provide an ethical code. The truth of existentialism in which moral agency is rooted is that each individual must define himself
or herself. Only they can identify what it is to be authentic. Thus, moral agency goes beyond one’s capacity to direct actions to an ethical end as it also includes acting in good faith. An individual who seemingly relinquishes freedom, choice, and responsibility to avoid moral uncertainty or ethical dilemmas is acting in bad faith even if they reach some ethical end.

Reading this definition, the CNACE portrays institutional values as homogenous to its members’ values. However, this assumption is problematic in a system as diverse as healthcare. Further, it seems to interpret moral agency as ‘black and white’. In reality, a moral dilemma may not have a clear direction of what is right or wrong, and institutional constraints may appear to block the path to the “right” ethical end. Considering this, it seems unrealistic to expect that nurses recognize unclear moral issues, display moral courage, and respond in the “right” behaviours. This is especially true considering that the healthcare environment is only beginning to open its doors to a moral discourse that includes nurses. To continue to accomplish this, it is imperative that the Canadian healthcare system empowers nurses to have moral agency. To further understand the role of moral agency in healthcare, it is important to explore the distress created by moral dilemmas and organizational pressures on nurses.

2.3 Moral Distress

In 1984, Andrew Jameton created the term moral distress, to describe an experience when individuals know the right thing to do but feel they cannot do it because of external or internal factors. External constraints can be institutional, administrative, legal, or social limitations such as understaffing and policies within healthcare (Carnevale, 2013). Internal barriers are personal; they surface when a nurse’s personal values conflict with what is
required (or not required) by their organization or their professional standards of practice (Jameton, 1984; Rodney et al., 2012). Jameton suggested that healthcare organizations have the power and capacity to limit the moral agency of its personnel. A nurse may know what choice to make, but for numerous reasons such as institutional limitations, the nurse may not be able to prevent an adverse event. The example below illustrates a scenario where nurses encounter moral distress because of organizational constraints.

It is the evening shift on a very busy medical-surgical unit and two of the four nurses scheduled to work have called in sick. Only two nurses remain. Each nurse will have twice as many patients as usual. This is especially problematic because the number of nurses that work on this unit has already been reduced from five to four because of budget reductions; nurses already find it difficult to provide adequate care. The nurses reported their profound worry about their workload to their nursing supervisor, but the supervisor told them that there was nothing that she could do and instructed them to do their best. (Carnevale, 2009, p. 34)

This situation is distressing because the nurses’ concerns are not recognized as important (Carnevale, 2009). By working understaffed, nurses struggle to maintain a high level of care. Such situations threaten nurses’ core values and principles while putting them at risk of not adhering to their association’s code of ethics to put patients first. Hamric (2001), has suggested that nurses are vulnerable to moral distress because nurses’ ethical and moral reasoning occurs in a multidisciplinary context. This signifies that nurses may face situations where they feel caught between patients/families, physicians and/or administrators. In these situations, nurses may understand their responsibilities towards patients/families, but feel constrained as a consequence of their limited authority in the healthcare environment. Moreover, nurses constantly turn their emotions on and off to minimize the impact their personal values have on the care they provide and should also do this to cope with challenging experiences. Howe and colleagues (2012), explained that
“shifting between different moral contexts can itself represent a risk for moral injury” (p. 352).

In February 2017, a panel of five scholars: Epstein, Beil, Wiencek, Rodney, and Lehmann, discussed the impact of moral distress at the organizational level (Sofer, 2017). The group stressed the cost-savings aspect of having programs to minimize moral distress in health systems (Sofer, 2017). They stated that employees are less prone to leaving their profession if they believe they can exercise professional and moral judgments (Sofer, 2017). They also discussed the Critical Care Nurse Work Environment Survey conducted by the American Association of Critical-Care Nurses (AACN) in 2006, 2008 and 2013. The most recent study surveyed 8444 AACN members, and the results suggest that the frequency of moral distress among nurses is at its highest recorded (Ulrich, Lavandero, Woods, & Early, 2014). Additionally, the variable that has worsened the most since 2006 is effective decision making (Ulrich et al., 2014). For the researchers, it is concerning that nurses’ perception of their ability to impact decision making has decreased significantly since 2006. Moreover, the nurses’ perceptions of quality care have also decreased since 2008 (Ulrich et al., 2014).

Moral distress has been studied in a variety of specialties such as oncology, pediatrics, emergency, palliative and long-term care (Rushton, Caldwell, & Kurtz, 2016). It appears it may also lead to decreased quality of patient care and poor patient outcomes (Rushton et al., 2016). The implications of moral distress on nurses suggest that it is similar to burnout (Dalmolin, Lunardi, Barlem, & Silveira, 2012). However, Weinzimmer and colleagues (2014), assert that moral distress is distinct from burnout in that it includes going against core moral values, it violates personal integrity, and undermines moral
identity. Further, Thomas and McCullough (2015) add that at its core, moral distress is anguish that emerges in response to threats, challenges, or damages to individual and professional integrity. The consequences of moral distress are long-term psychological issues including withdrawal, emotional fatigue, depersonalization of patients, and burnout (Allen et al., 2013; Oh & Gastmans, 2015). Continuous moral distress can be detrimental to clinicians and lead to turnover (Rushton et al., 2016).

According to Rodney (2013), moral distress reflects nurses’ difficulties in exercising moral agency for reasons including “conflict with other health care providers, excessive workloads, and challenges with end-of-life decision-making” (p.314). When values and commitments are compromised, nurses’ integrity and role as moral agents are minimized, and they may become morally distressed (CNACE, 2008). Rushton and colleagues (2016), believe nurses have an obligation to their patients, but also a responsibility to address their personal suffering. According to their research, moral distress can serve as a positive catalyst for growth. Difficult experiences can be used to transform distress into moral resilience.

2.4 Moral Resilience

Moral resilience is defined as “the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks” (Rushton et al., 2016, p. 44). It encompasses the ability to exercise existential courage by adhering to one’s moral action regardless of opposition or obstacles. It also includes the ability to acknowledge when one has exercised enough effort to meet personal and professional ethical obligations while understanding “one’s limitations, the constraints and pressures of the situation” (p. 44).
Similarly, psychological resilience assesses one’s ability to thrive under pressure and bounce back from stress (Hart, Brannan, & De Chesnay, 2014). The concept is comprised of three “hardiness” factors: commitment, control, and challenge (Maddi, 2013). These three terms are interrelated and conceptualize the meaning of existential courage as a set of attributes for resilience (Maddi, 2007).

In the last 20 years, research on resilience was identified as an important factor for lifelong health and well-being (Haskett, Nears, Ward, & McPherson, 2006) which also seems to increase caring outcomes in nurses (Jackson et al., 2007). Characteristics of hardiness reduce feelings of alienation, employee turnover, powerlessness, burnout while improving overall job performance, and problem-solving skills (Bowsher & Keep, 1995; Maddi, 2002, Marques da Silva et al., 2014). Thus, hardiness and resilience influence significant factors of professional work (Abdollahi, Talib, Yaacob, & Ismail, 2014).

Further, the concepts of positive adaptation and coping overlap with resilience (Fletcher & Sarkar, 2013). Individual assets and protective characteristics such as self-efficacy and persistence facilitate resiliency (Windle, Bennett, & Noyes, 2011). Therefore, resilience is a dynamic process in which growth and adaptations occur (Rutter, 2012). In difficult situations, positive adaptation and coping join the moral resilience continuum to facilitate self-care and maintain and seek social supports (Jackson, Firtko & Edenborough, 2007; Maddi, 2002). This is particularly important for professionals in stressful occupations such as healthcare.

The components of moral resilience and hardiness allow individuals to value persistence, making challenging experiences surmountable (Maddi, 2002; 2013). Over time, the outcome of hardy attitudes represents an expression of one’s potential and
capabilities (Maddi, 2007). This aligns with moral agency and influences on the meaning nurses find in their profession.

2.4.1 Meaningful Work and Hardiness.

Through moral resilience, individuals may find meaning in situations that threaten integrity or conflict with one’s moral identity (Rushton et al., 2016). Human experiences differ in meaning based on individual choices, values, and behaviours. Existential philosopher Frankl (1964) confirmed this when asserting that humans have the capacity to choose meaning in life. Later, Frankl (2010) mentioned three ways in which meaning is found in our actions, in our relationships, and our attitudes towards suffering. Previously, Kobasa (1979) explored meaning in work and discovered that it is a derivative of resilience. It was recognized by Pavlish and Hunt (2012) that “scant evidence exists about how nurses find meaning in their work or the workplace factors that influence nurses’ perceptions of meaningfulness” (p.113). In 1964, Frankl suggested that finding meaning in work sustains individuals through adverse events. Antonovsky (1987) observed that resilient people manage stress and their well-being by finding meaning in their work and deriving purpose from seemingly overwhelming situations.

Further, Malloy and colleagues (2015) interviewed 60 nurses internationally on fostering meaningful work in challenging nursing practices. They offered four themes in which meaning is found; relationships, compassionate caring, identity, and mentoring culture. These are closely related to the caring values of the Canadian Nurses Association Code of Ethics (2008). Malloy and colleagues (2015) stress “the need for a workplace that fosters personal growth through meaning...” (para. 1). Finding meaning in work helps nurses overcome situations of stress and successfully cope with the demands of the
profession. Potentially, excessive challenges in finding meaning, or in making a difference undermines resilience in nurses and consequently reduce moral agency.

A study with medical students on life satisfaction and resilience in medical school found correlations between low levels of resilience and passive distress through students’ inability to intervene in emotionally disturbing events (Kjeldstadli et al., 2006). Resilience allows individuals to develop efficient coping strategies leading them to understand contexts and analyze situations (Grant, Ramcharan, & Flynn, 2007). Resilience is an anchor in difficult circumstances; it enables administrations to minimize poor practices while promoting professional values that empower nurses to find meaning in work (Warnock, 2008).

Moral resilience and meaningful work appear important for the development of moral agency. To further understand the context in which moral agency occurs one should understand organizational culture and bureaucratic intensity.

2.5 Bureaucracy

In 1947, Weber argued that bureaucracy was the most efficient and rational way to organize human activity. Still today, principles of bureaucratic theory; impersonality, hierarchy of authority, abstract rules, specific skill requirements, and task allocation are believed to maximize productivity and rationality in decision-making (Gouldner 1964; Hodgkinson, 1991; Malloy, 1992; Reinehart, 1987). These principles ensure individual behaviour is organizationally authorized (Malloy, 1992) and demonstrates a commitment to rationality, and managerial efficiency (Hodgkinson, 1983).

In theory, bureaucracy seems ideal as it allows for effectiveness, efficiency, and productivity; however, it does not create an organizational culture where individuals can
be authentic. Gouldern (1964) established that abstract rules create control, while also instituting a minimum which becomes the performance norm. This can be counterproductive as the organization’s performance becomes limited by individual uniform commitment. The norm of impersonality and rationality is further criticized by Hodgkinson (1991) explaining that in complex bureaucracies people are dispensable, conversely, morality includes the totality of one’s personality, values and core beliefs. In any professional role, one’s morality will play a part even if it is considered irrelevant to their bureaucratic systems.

In health systems, nurses face ethical challenges in aiming to provide quality care and challenge organizational deficits (Smets, Visser, & Orrt, 2004). In a bureaucracy, even if nurses are hired based on specific skills, personal morality overflows into their role and influences professional practice. According to Guigon (1986), “the authentic agent might be better equipped to evaluate different ethical standpoints and their applicability to specific contexts of action than the slavish rule-follower or the cool cost/benefit calculator” (p. 88). In this context, the individual may have a greater understanding of responsibility. An authentic awareness leads to informed decision making. According to Agarwal and Malloy (2000), this will “foster a greater sense of commitment and awareness to the missions and goals of the organization.” (p. 153). It can be daunting for organizations to foster this freedom in its organizational culture; however, “disempowerment within the structures and systems of one’s work can also be damaging” (Howe et al., 2012, p. 352).

Jameton (1990) discussed the parallel between agency and context in stating; “we want, as participants in institutional culture, to be able to notice our moral problems and to cope with them with sensitivity and to keep our health care institutions responsive to
their moral goals” (p. 450). From the perspective of individuals working in bureaucratic settings, moral agency appears to be influenced by organizational culture.

### 2.5.1 Organizational Culture.

Culture appears to be the glue that holds organizations together (Goffee & Jones, 1996), it unifies through a pattern of shared assumptions within an organizational context (Schein, 2004). Characterized by the implicit “correct” way to perceive, think and feel, organizational culture leads through compelling vision, a system of shared values, and meanings (Schein, 1992; 2004). Edgar Schein, the father of organizational culture, demonstrated that culture is complex because of the existence of implicit assumptions that cannot be exposed through external observation or measured through surveys and quantitative assessments (1992, 2004). Organizational climate are observable elements, practices, procedures, and rewards of the institution (Schneider, Gunnarson, & Niles-Jolly, 1994). An institution’s overarching moral climate influences perceptions of moral agency (Rushton, et al., 2016). The culture that includes conflict, heavy workloads, and power dynamics can prevent people from exercising moral agency (Epstein & Delgado, 2010). This is significant as organizational culture runs deeper than climate, making it “stable and hard to change” (Schein, 2004, p.393).

Schein’s (1992) model of organizational culture describes three integrated levels that resemble the structure of an onion. The outer layer of the model are artifacts displaying the physical and social context of organizational members and explicit communication behaviours in the culture. Artifacts surround the onion as they are a manifestation of the organization’s espoused values and core assumptions. In a hospital, observing collaborations, and interactions between staff of all specialties illustrates what is valued.
Problems can arise when the ideas of nurses are not in line with the basic assumptions of the organization. The second level of Schein’s model encompasses the public or espoused values an organization aims to follow (Schein, 1992). In an organization, there may be a difference between the organization’s official values and the manifestation of these values as seen through behaviours (Miller, 2012). Values are closely linked to the core of an institution and its culture as they may represent the outcomes of implicit assumptions.

At the core of Schein’s onion are ontological assumptions referring to how organizational members view the world. Core assumptions are embedded in organizational culture and may be difficult to identify as they are implicit and presumed. In a hospital, this may be illustrated through the caring goals of the staff. At its core, every position in a hospital, whether cafeteria chefs, nurses, physicians or lab technicians, has the objective to care for patients and improve health outcomes. This core assumption to promote patient recovery travels from the food provided to the medicine prescribed and treatment plan thought out. However, at the core of a bureaucratic culture such as healthcare can also be values of efficiency, effectiveness, and productivity. In this organized culture, it is common to observe structured levels of reporting, hierarchy, and normalized behaviours to ensure efficiency in services provided and maximize patient flow. In this context, enacting moral agency involves risk, as it contradicts core assumptions exhibited within health organizations (Raines 1994). Peter and Liaschenko (2013) also found that in healthcare, teams are often hierarchical, with power dispersed unevenly. Nonetheless, such organizations like hospitals may be authentic if its members are aware of its core limitations and encouraged to enact moral agency to bridge the gap between institutional goals of bureaucracy and the caring components of their profession.
Schein’s model has been criticized as simplistic and linear in the study of organizational cultures. However, it offers a practical process to categorize and analyze components of organizational cultures (Miller, 2012). Further, Schein’s model of organizational culture demonstrates the potential influence of organizational power on individual behaviours. Stanley Milgram’s research experiments (1974) demonstrated the power of this relationship. In short, the experiment asked subjects to administer supposed electric shocks to an alleged victim upon request from various individuals impersonating an authoritarian figure. The results revealed, “a (strong) willingness to obey figures of authority in an organizational hierarchy” (Hodgkinson, 1983, p.66). This means that in a setting of formal organization (i.e., hospitals), individuals have a willingness to obey authoritarian figures. The subordinate psychological “agentic state” (Hodgkinson, 1983, p. 66) disappears in a context where formal authority is present dictating a behaviour pattern. Institutions have a strong influence on human behaviour; individuals should be conscious of their moral agency to minimize this power imbalance.

Schein’s onion model also provides points of reference to undertake cultural changes which could be important in healthcare. According to Schein (1992), the basis of cultural change is embedded in discussions with members of the organization. Dialog and interactions begin the transformation process necessary in organizations to uncover core assumptions. In healthcare, a nurse exhibiting moral agency cares based on having internalized their role and engaging with moral imagination in the face of uncertainty (Raines, 1994). Lindemann (2013) believes that this identity is an interaction between one’s view of oneself, others’ perception of them, and the culturally approved identity of nurses. Lindemann also states that moral identity is the “lever that expands or contracts
one’s ability to exercise moral agency” (Lindemann, 2001, p. xi). Therefore, it is essential to “deliberately think of health care institutions as moral communities, [as] we more easily create space for moral discourse…” (Liaschenko & Peter, 2016, p. 19). Thus, fostering healthcare environments that value and endorse moral agency, minimize power imbalances and yields to accountable nursing practice.

The topics explored in this literature review further emphasize the relationship between moral agents and the organization in which they practice. As described by Liaschenko and Peter (2016) it may be “the most challenging moral problem of the twenty-first century. . .” (p. 18) as the consequences of bureaucratic constraints appear to impact the well-being of nurses and patients.
CHAPTER THREE: Methodology

In this chapter, I describe the methodology and methods used in this thesis. I determined that a qualitative approach was the most appropriate for addressing the research questions that emphasize the description of the healthcare context. Additionally, interviews provided an avenue for nurses to have their voices heard. I determined that De Groot’s methodology and thematic content analysis were congruent with the research questions and the most appropriate approach to focus on understanding factors; the variables of nurses’ experiences. In this chapter, I explain my epistemology, followed by explaining De Groot’s methodology and the methods of the research. This includes the discussion of the sample characteristics, recruitment, consent and confidentiality. I also explained how data were collected and analyzed using thematic content analysis. Finally, trustworthiness and potential limitations are described.

3.1 Epistemology

Methodology links a researchers’ epistemology to their selection of a research approach (Creswell, 2014). Considering this, my epistemology interconnects with how interview questions are developed, and data are collected and analyzed (Creswell, 2014). Epistemology guides definitions of truths which lead researchers in acquiring new knowledge (Whaley & Krane, 2011). This research is based on a constructivist worldview as it acknowledges the possibility of multiple truths and considers the meaning individuals ascribe to experiences (Blumer, 1969; Piaget, 1971). Constructivism seeks to comprehend the human experience through an inductive approach (Creswell, 2014; Piaget 1971). It emphasizes that knowledge is subjective and formed through interactions (Mead, 1934;
Likewise, meaning is constructed as individuals engage in society (Mead, 1934; Blumer, 1969; Piaget, 1971). I understand the influence of constructivism on their role as a primary investigator as the research question, methods, and approach were created to emphasize meaning. While I rely on the perspectives of participants on various data collection methods, constructivism influences how information is interpreted, coded, and analyzed to accentuate multiple truths (Creswell, 2014). Through this epistemology, I can focus on the participant’s meanings.

3.1.1 De Groot’s Methodology

The interpretive theoretical approach by De Groot (1969) was selected at the beginning of this thesis as it has philosophical and practical foundations in qualitative research (Malloy, 1992). Aligning with existentialism, De Groot’s approach perceives reality as a function of individuals and highlights understanding the human condition. There are four qualitative phases in De Groot’s interpretive approach. In its 1969 version, these stages were exploration, description, classification, and explanation. In 1982, Wright reclassified the second phase as analysis.

Phase I: Exploration.

The first phase of De Groot’s methodology is exploration. This phase includes finding sources for data pertinent to the research inquiry and the development of research questions. This exploration is the foundation for the literature review, research questions, procedures, and methodology.

Phase II Analysis (Description).
The literature review describes the importance of moral agency, the role of organizational culture, and the impact of moral distress. In this section, I provide literature to the reader to help them understand the problem at hand. The purpose of this phase is to identify “…significant patterns of dependence which may be formulated as a tentative hypothesis” (De Groot, 1969, p. 53). Though the literature review is a significant part of the research, the analysis phase considers the participants as the primary source to formulate hypotheses.

**Phase III Classification (Thematic Content Analysis).**

As I moved through the qualitative process of De Groot’s methodology, phase III classification appeared too restrictive for the analysis. I found this phase overly structured and difficult to apply in the naturalistic climate in which data was collected in this study. The interviews were semi-structured and the questions were asked in various ways and ordered based on the participants’ experiences. De Groot’s structured nature did not do justice to the gravity and seriousness of the nurses’ trauma and experiences. I had to adjust how questions were framed, phrased and ordered based on the needs of each participant. De Groot’s methodology techniques for classification, are precise and systematic, there is a specific format I would have had to follow in asking questions and in analyzing the qualitative data. For example, it would be traditionally required through De Groot’s methodology to analyze each question asked (i.e., all of question 1 etc.) rather than analyze each participant’s transcript. This technique was not applicable because questions needed to be adjusted for the needs of each participant. Further, analyzing each transcript in its entirety appeared more appropriate as it allowed me to have an inclusive perspective of each participant’s experiences. Further, to do a comparison between the Novice to Expert
nurses I wanted to analyze all of the Experts’ transcripts followed by all of the Novices’ transcripts. It would have been impossible to separate all of the participant’s responses by group and questions using De Groot’s traditional analysis and classification techniques. Therefore, I made a shift towards thematic content analysis, applying De Groot’s methodology in a new way (See 3.2.7 Data Analysis for more explanation).

**Phase IV Explanation.**

In phase four of de Groot’s methodology, I explored findings through discussion and recommendations. In the findings, having a visual representation of the themes helps the reader understand the research. This interpretive schematic is based on the thematic analysis of the data obtained and theoretical links between the themes and categories. In 1982, Wright proposed that models demonstrate an overall comprehension required before theory can be extended to practice. Consequently, interpreting results through a visual allows me to understand the essence of a phenomenon in the social world (Creswell, 2014). This phase connects the thesis together as it discusses the significance of the research and its findings based on previous and current research in the field.

**3.2 Methods**

The sections below describe the specific methods of the research; data collection, sampling strategies for recruitment, participant characteristics, sample location, details on the consent form, and data analysis. I also discuss trustworthiness, and potential limitations to the research.
3.2.1 Sampling Overview.

This study involves purposive and snowball sampling by enlisting twenty registered nurses in a Northern Urban healthcare context. Registered nurses were selected as they represent the frontline to healthcare services. Upon receiving ethical approval, semi-structured individual interviews were conducted. The interview method allows for flexibility, depth, and insight into the experiences of nurses.

3.2.2 Sample Characteristics.

Eligible participants were registered nurses licensed by their province’s Registered Nurses’ Association working in the designated Northern Urban setting. Recently retired RNs (less than one year) were also accepted in the research. Based on Benner’s (1984) work, Novice participants needed one to five years of clinical experience in nursing. To be considered as an Expert, participants needed five or more years of experience as they have a more extensive exposure to the healthcare system. I wanted to interview two groups of similar size and ended with 11 Novice and 9 Expert participants. Within this population, eligibility criteria were open to males and females of any age, any nursing specialty, and of any cultural or ethnic backgrounds. Participants were excluded if they did not fit the characteristics mentioned above. In the end, participants were all females with experiences in acute and or long-term care. (For details see Appendix A; Participant characteristics)

3.2.3 Sampling Method & Recruitment.

I aimed to recruit 20 registered nurses as this sample size is based on sampling recommendations for qualitative research (Creswell, 2014). This sample size is ideal for qualitative research as it allowed me to explore rich descriptions of the context in which nurses’ work and explore their experiences. I recruited participants using purposive
sampling, as well as a traditional and modified snowball sampling. In its traditional form snowball sampling requires me to find participants through referrals. Three participants were recruited this way. The referred individuals were then selected to participate based on the eligibility criteria (purposive sampling). Through modified snowball sampling, I contacted individuals in the region through social media and invited them to participate in the research using an approved letter of recruitment (See Appendix B). Seventeen participants were recruited this way. As an incentive to participating in the study, each participant received a ten-dollar gift card.

Overall, twenty-five nurses were recruited and interviewed for the research. However, at the start of their interviews five participants revealed that while being nurses they were not licensed registered nurses. Therefore, these participants did not meet the inclusion criteria and were excluded from the research. They did receive the ten-dollar gift card incentive. Omitting these five participants simplified the data analysis and permitted me to reach conclusions specific to registered nurses.

3.2.4 Sample Location.

Sampling recruitment and data collection were focused on a Northern Urban community. To protect the confidentiality of the participants, I refrain from naming the community, however, this community serves as a hub for primary health care services to Northern communities.

3.2.5 Consent & Confidentiality Agreement.

Before the beginning of the interview, I gave participants time to read and sign the informed consent and confidentiality agreement form. The consent and confidentiality
agreement include the purpose of the study, the rights of the participants, and explains the potential benefits and risks to participating (See Appendix C).

3.2.6 Data Collection.

Ethical Approval from the Research Ethics Board, University of Regina, was requested in late April 2017 and received in early June 2017 (See Appendix D). The recruitment process began in late June and the data collection began mid-July. Semi-structured interviews were the method of data collection as they provide some structure while being flexible so the participants could share spontaneous descriptions and stories (Brinkmann, 2014; Pope, Royen, & Baker, 2002). I followed an interview protocol developed based on understanding the following; De Groot methodology (1969), Benner’s work (1984), existential philosophy (Sartre, 1985), as well as current research on moral agency and moral distress. The guide included open-ended questions while attempting to maintain a conversation with the participants (Pope et al., 2002). It was approved by the supervisor and research committee. The questions were structured from least invasive to most invasive and from least threatening to most threatening. Semi-structured interviews were an ideal method for data collection as it allowed participants to describe their experiences while I listened and asked probing questions (Creswell, 2014). I also took notes during the interviews with participants and maintained a reflexive journal. The sessions, 20-90 mins in duration, were audio recorded and transcribed verbatim. Each participant obtained a transcript of their interview to ensure that information conveyed in the interview was accurate and that they agreed to have what they said, serve as data. The interview questions focused on moral agency and moral distress by inquiring on nurses’
experiences in healthcare (See Appendix E). Questions also targeted perceptions of organizational context by examining perceived decision-making ability, structural or organizational barriers, and opportunities to find meaning in work.

The advantages of performing interviews face to face as a method for data collection were that it allowed me to follow up on certain questions and observe the participants’ reactions. I also acknowledge the drawbacks of conducting a single interview with participants, such that participants may be hesitant to open up since trust has yet to be established. However, this drawback was not a limitation to this research as participants provided rich and descriptive data. As well, there is a limitation such that certain individuals may be better than others at expressing and articulating themselves in the interview. I alleviated this limitation by recruiting participants until reaching a robust data set. Saturation is a theoretical ideal, however, 300 pages single spaced of high quality data was collected, and I found clear patterns with depth and breath establishing a robust data set.

3.2.7 Data Analysis.

As explained in Phase III of De Groot’s methodology, I used thematic content analysis to examine the data in relation to the research questions (Braun & Clarke, 2006). Thematic content analysis has been described as “a method for identifying, analyzing, and reporting patterns (themes) within data” (Braun & Clarke, 2006, p.79). Thematic content analysis is often used in nursing studies as it allows for the description of the context influencing the nurses stories (Vaismoradi, Turnen, & Bondas, 2013). Thematic content analysis is an ideal approach for this thesis as it allows me to combine the meaning of nurses’ experiences to their professional context (Joffe & Yardley, 2004). This method is
also appropriate for analysis of multifaceted real-life experiences in nursing that can be sensitive (Vaidmoradi et al., 2013). Qualitative descriptions through thematic content analysis are a way to present and discuss collected data “as living entities that resist simple classification” (Vaismoradi et al., 2013, p. 399). The method includes exploration and identification of themes arising from a set of interviews (DeSantis & Ugarriza, 2000). Using this method, codes and categories were developed to form descriptions of specific ideas while helping to identify underlying themes within the interview transcripts.

Braun and Clarke (2006) established the six steps to conducting thematic content analysis. The first step involves becoming familiar with the data by transcribing the recordings and reading through transcripts multiple times to identify initial ideas. I completed this step between September 2017 and November 2017. During this initial phase, I did not differentiate between the two groups of nurses. Rather, I looked at each transcript individually to gain an understanding of each participant’s experience. This was followed by step two; generating initial codes by thoroughly coding the data across the data set. I coded words and phases based on meaning. Words such as time, understaffing, politics, and end of life were used as codes to represent reoccurring ideas within the transcripts. Phrases were highlighted to capture abstract concepts such as exemplars regarding end of life care, and the organizational context.

The third step involved searching for themes by categorizing codes into patterns, and by grouping in charts all relevant data for each preliminary theme. While categorizing is intuitive, it was important to me to follow a logical process to develop categories (Guba & Lincoln, 1982). Therefore, to become part of a category, similar experiences had to be shared by multiple participants. If the majority of the nurses in the groups discussed similar
experiences regarding specific topics such as end of life care it was grouped together as it became apparent that this was an important pattern. I completed steps two and three for the two separate groups, Novice and Expert, between November 2017 to January 2018. During this period, I met with nursing expert, Dr David Gregory, on three occasions for two hours each time to discuss the data and go through a transcript picked at random. Peer debriefing can be a beneficial way to increase the trustworthiness of the findings (Lincoln & Guba, 1985).

Following this, I refined preliminary themes through ongoing analysis to construct the overall story told in the data. Through this step, I compared the two groups of participants Novice and Experts by looking at the differences and similarities between the two. The themes interconnected the experiences of the participants while encapsulating the essence of the transcripts. It was important to acknowledge that categories were not synonymous to themes (Morse, 2008). Multiple categories such as time, workload and staffing were used to create a theme. The themes are meaningful and represent the essence of the data (Morse, 2008). They were found by thinking interpretively about the meaning of the data. For instance, as I read an exemplar, I asked: “What does the participant wish to convey? How does this relate to what other participants have shared?” This helped me in linking categories and finding important statements. Steps four and five occurred between February 2018 to April 2018. During this period, I met with the nursing expert one time for 2 hours to discuss potential findings. The last step involved producing the report which involved the selection of rich, compelling exemplars and relating it back to the research questions and literature. This step occurred in April and May 2018. In the findings, I provided rich descriptions of the participants’ experiences through vignettes.
(Creswell, 2014). However, I changed superficial details in the exemplars to ensure confidentiality of the participants and individuals in the stories.

Overall, this systematic analysis process allowed data to be organized into patterns that identify and describe explicit ideas while emphasizing implicit relationships and themes within the data sets (Creswell, 2014). This specific process was important for this data set because of the naturalistic climate for data collecting, and the sensitive experiences revealed by participants.

3.3 Trustworthiness

In this study, triangulation was used to increase the trustworthiness of the research through an informal reflexive journal, peer debriefing and giving transcripts back to participants. I maintained a reflexive journal during the data collection and the data analysis process to document thoughts, interpretations, and reactions to the data while making connections to the research questions and acknowledging assumptions (Cutcliffe, 2003; Finlay, 2002). This reflexive practice strengthens the rigor and credibility of the research process (Starks & Trinidad, 2007). Further, I performed peer debriefing with research supervisor, Dr David Malloy, and committee member Dr David Gregory to confirm the findings and discuss the analytic process. Additionally, I sent the transcripts back to participants and they received the research abstract. Through triangulation these various methods were used to increase the trustworthiness of this research.

3.4. Potential Limitations

The parameters of this study; only included registered nurses. Further, registered nurses willing to participate in a study on moral agency may be more prone to being moral agents in their work or wish to challenge the health care system. Further, there may be
limitations in the participants’ understanding of the differences between ethics and morals such as the differences between a moral dilemma and an ethical dilemma. Therefore, the results of this qualitative study do not aim to represent the experiences of the nursing population. Rather, the findings of this research describe the experiences of nurses in a Northern urban setting and more research is needed to understand if this reality is transferable across other locations.
CHAPTER FOUR: Findings

In this chapter, the research questions are answered by discussing the findings of the study. Twenty interviews conducted with participants who explained their experiences as registered nurses (RNs) working in a Northern Urban setting were analyzed. The themes described represent their realities pertaining to moral agency, moral distress, and organizational context. Besides each quote are numbers which state the location of the quote in the original transcripts. These numbers may help the reader see that quotes are varied and chosen from across the entire transcript set. Before delving into the findings, I would like to emphasize that the Canadian healthcare system is one of the best and most recognized in the world. As Canadians, we are privileged to have access to such a sophisticated and proficient system. Patients can expect to receive successful care in every province without fear of placing financial burdens on their families. My goal was to critically inquire on areas that need improvements in nursing ethics to bring awareness to moral agency and moral distress.

In this study, of the 20 RNs were recruited, 11 were Novices and 9 were Experts. The participants were all females, their ages ranged from 24 to 57, and participants were of various ethnic backgrounds. The average years of experience was 12.8, with a range of 1 to 36 years and participants had experience in acute and or long-term care.
4.1 Overview of Findings

The themes illustrated in the table below emerged from the data analysis. Theme one illustrates the organizational context Novice and Expert RNs face, theme two; the development of RNs voices, and theme three; the impact of moral agency and moral distress in end of life care situations.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Organizational Context: Factors impeding Moral Agency and leading to Moral Distress among RNs</td>
</tr>
<tr>
<td>2</td>
<td>Growth of Moral Agency: How RNs develop voice</td>
</tr>
<tr>
<td>3</td>
<td>Moral Agency and Moral Distress in End of life Care</td>
</tr>
</tbody>
</table>

The first theme is “Organizational Context: Factors impeding Moral Agency and leading to Moral Distress among RNs”. This theme represents three factors appearing to impede moral agency and lead to moral distress among RNs; understaffing, heavy workloads, and lack of time. The RNs’ experiences regarding these factors are separated into two groups: Novices and Experts, which shows the similarities and differences between the two groups. A consequence of the organizational context appears to be the negative perceptions RNs have of healthcare administration which is also separated into two groups Novice and Expert.

The organizational context that Novice and Expert RNs work in also impacts the development of their moral agency in a bureaucratic system. The second theme “Growth of Moral Agency: How RNs develop voice” explores the development of voice for Novice and Experts by looking at two sub themes “Novice RNs’ Voices in a Bureaucratic System”
and “Expert RNs’ Voices in a Bureaucratic System”. Novice and Expert RNs have different voices in the healthcare system; Novice RNs suggest that they are unheard beyond responding to patients’ immediate needs. This is distressing to them as they strive to survive and make differences in the system while facing organizational constraints. Expert RNs understand this feeling and explain their journeys to finding their voices in the system. An expression of moral agency also includes one’s ability to develop relationships with others. A difference between the two groups was that Expert RNs have the ability to develop therapeutic relationships with patients and families while facing the same organizational constraints as the Novice RNs. For example, in facing end of life care situations, it is important for RNs to have a voice.

End of life care represents an area where the context of the organizational culture, moral distress, and the moral agency of RNs interact. This leads us to theme three “Moral Agency and Moral Distress in End of life Care” which is separated into two subthemes “Moral Agency and Moral Distress in End of life Care: Novice RNs” and “Moral Agency and Moral Distress in End of life Care: Expert RNs”. Through the similarities and differences between the two, it is possible to see how various factors such as the structure of advance care directives and family dynamics can impact RNs’ voices and increase moral distress.

Based on De Groot’s methodology a model was developed to represent the findings. The model below demonstrates the interaction between the themes and the difference and similarities between Novice and Expert RNs. The left column demonstrates the similarities; the organizational factors such as understaffing, heavy workloads, and lack of time spirals down to create a negative organizational culture. In this context, moral distress
appears to increase and moral agency decreases while the RNs perceptions of the administration become more negative. In the right column, are the differences Novice and Expert RNs encounter in the development of their voices. Working in the healthcare system, Novice RNs face an environment high in expectations and demand. They experience moral distress and it can be difficult for them to exercise moral agency. Novice RNs need to be morally aware from the start of their careers. Expert RNs face the same organizational constraints but have adapted to survive in the system; they keep going. Through their years of experience, they have learned to use their moral agency, but they can still encounter situations where their voices are unheard because of the structure of the system. As a result, they can still experience moral distress. All of these themes come to play in end of life care as it this area exemplifies how the context of the organizational culture, moral agency and moral distress interact in the healthcare system through the structure of advance care directives and family dynamics.
Model Representing Findings

<table>
<thead>
<tr>
<th>Similarities</th>
<th>Differences</th>
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<tbody>
<tr>
<td>Understaffing</td>
<td><strong>Novice RNs</strong></td>
</tr>
<tr>
<td>Heavy workloads</td>
<td>- Face High Expectations</td>
</tr>
<tr>
<td>Lack of Time</td>
<td>- Experience moral distress</td>
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<tr>
<td>Moral Distress</td>
<td>- Difficulty exercising moral agency</td>
</tr>
<tr>
<td>Moral Agency</td>
<td>- Must be morally aware</td>
</tr>
<tr>
<td>Negative view of admin.</td>
<td>- Example: End of life care</td>
</tr>
</tbody>
</table>

**Expert RNs**

- Adapted and Survived: *Keep going*
- Speak up, not always heard
- Can still experience moral distress
- Example: End of life care
4.2 Theme 1: Organizational Context: Factors impeding Moral Agency and leading to Moral Distress among RNs

Expert RNs and Novice RNs identified structural factors impacting moral agency and potentially leading to moral distress by influencing quality of care in the healthcare system. The demanding nature of nursing work illustrates the seriousness of moral distress and it is important to understand the organizational factors leading to moral distress. Factors such as understaffing, heavy workloads, and time constraints appear to lead to moral distress among Novice and Expert RNs. The subthemes separate Novices and Experts as the two groups experience the organizational structures differently in the same context. The healthcare system is under considerable pressure and the learning curve is steep as Novice RNs feel the urgency to meet the needs of patients efficiently. Expert RNs see how the system has changed over the years and describe adapting to survive under considerable pressures. They have developed the ability to keep going when encountering difficult experiences and challenges. Participants also discussed their nurses’ perceptions of the administration and their desire for increased support related to empowering nurses’ moral agency. However, the language used by RNs to describe upper echelons of healthcare was adversarial and did not appear conducive to building a team atmosphere. The perceptions of nurses demonstrated tensions in the healthcare system between senior managements’ cost saving values of efficiency and effectiveness and nurses’ patient-centered care values.
Novice and Expert RNs expressed that the area they work in is a healthcare hub for Northern populations. The people they serve have specific health needs that RNs find difficult to meet while being understaffed;

We serve a lot of the Northern population, we’re very busy, and it’s hard. We’re usually over capacitated too that’s hard, and we don’t have the funding to get more staff, so we’re just working more or harder. (Nurse 5, 2154-56)

Novice RNs find it difficult that they lack time to provide emotional and mental support to patients. Given heavy workloads, understaffing and time constraints, RNs find themselves focusing on meeting basic physical needs, while they would like to provide emotional and mental care. This organizational context can be a source of moral distress as there are tensions between system values and the fundamental values of the nursing profession.

Novice RNs explained that the workload is demanding and beyond what they imagined in school; “Our patient-load is nothing I could have ever imagined in school. . . I was just floored by what we have to deal with” (Nurse 1, 93-95). Novice RNs were not prepared for the intensity and urgency of the healthcare system. The pressures put on RNs are heightened when working short staffed; “We’re short a lot. . . and sometimes, you have your full staff and you still can’t manage because it’s so busy” (Nurse 1, 167-70). The organizational factors of heavy workloads and understaffing demonstrate a context where Novice RNs are under pressure to meet the needs of patients efficiently. However, this organizational structure may put patients’ safety at risk; “We always feel like we’re short-staffed. . .so it’s hard. Your charge nurse will often have a patient load and your charge
nurse shouldn’t have a patient load” (Nurse 9, 4162-66). RNs face heavy workloads and understaffing potentially limiting their abilities to provide safe quality care for patients.

We’ll have 15 to 20 patients in the waiting room. So unsafe. As a triage nurse, you’re expected to reassess these patients, you have a timer blinking at you, but you still have 7 you have to assess and you can’t leave those 7 because what if one of those is having chest pain? . . . I’ve just never known of a ratio of one nurse to 14 patients. That’s not safe either, because stuff happens and people die in waiting rooms. It’s the system though, I don’t think you can blame that individual. (Nurse 16, 8933-50)

Further, it is difficult for the nursing team when RNs call in sick because they continuously work understaffed; “When people call in sick, we don’t get replaced. . .our workload is our workload… So, if somebody calls in sick, you have to cover them it puts you behind on your work” (Nurse 4, 1496-98). This raises concerns for patient safety as RNs must meet the needs of all patients under time constraints. Some participants expressed feeling distressed and guilty in having to call in sick because they do not want to increase their colleagues’ workload;

I feel so bad because when I have to phone in sick because I know what it’s like to work short staffed. So, I’ll go into work sick and then you’re not taking care of yourself, physically, mentally, emotionally. You get burnt out, but you go in sick, that’s what you do. And that’s not safe for patients. (Nurse 16, 8956-63)

RNs shared having gone to work ill and express that it is a contributing factor to burning out. Nurse 16 also explained the potential risk for patients as a nurse is more likely to make errors while working ill. This issue demonstrates a systematic error within the healthcare system and its workplace context; “It comes down to a system’s error because why should I feel guilty for calling in sick? Because I’m leaving my team short? You can’t blame that individual because it’s the bigger picture as opposed to the individual” (Nurse 16, 8975-78). This statement also shows that feelings of guilt from calling in sick stem from leaving the team short, however, in the big picture of healthcare it is not the individual RN’s fault,
rather it represents a systematic issue of understaffing within the context of the health care system.

Further, Novice RNs explained feeling morally distressed when attempting to provide high quality care under time constraints. They learn to prioritize what type of care they provide and which patients get treated first; “I had to choose who was more in labour, so I could pay attention to them but in reality, they were all in labour. It’s so bad. . .You choose the sickest baby that needs more of your attention” (Nurse 1, 173-79). Having to prioritize patients may lead to distress for RNs who want to provide the best care to each of their patients. RNs want to develop a relationship with patients and be advocates for them, but the reality is they do not have time. This can be a source of moral distress for RNs as it appears to contradicts the values that led them to the nursing profession, additionally it can impact patients and their families:

Time constraints are really hard. We’re very busy and usually over capacity. So many patients could benefit from cognitive therapy such as doing a puzzle with them or sitting with them and visiting or having that time to help them put their clothes on. I feel that I don’t have time to do this because you have to prioritize your time. . . It takes away from that therapeutic communication and that relationship and makes it feel more task-oriented and we didn’t learn to be task-orientated. We learned therapeutic communication, empathy, being able to advocate for your patient and it’s too bad that reality doesn’t let you do that. (Nurse 17, 9518-32)

There is a discrepancy between reality of care versus the level of care RNs want to provide because of time constraints. RNs want to go beyond being task-oriented, they want to provide a level of care positively impacting patients’ experience in hospital. Further, in a high-pressure environment Novice RNs strive to be as efficient as possible, but that can lead them to forget about the patient as a person; “You want to be as fast and efficient as
you possibly can and sometimes you forget that they’re people” (Nurse 9, 4452-53). In the current organizational context, it is easy to forget the personhood of patients;

We definitely aren’t Florence Nightingale nursing anymore. We’re very task-oriented and sometimes you forget that you’re treating people and people’s families and communities. I feel like we forget that patients have emotions just like the rest of us. It’s hard, it’s frustrating because you try to go from patient to patient without breaking stride but yet at the same time, you’re not treating the same patient in every room. (Nurse 9, 4456-61)

This dilemma shows that in an effort to be productive, it can be difficult for Novice RNs to provide compassionate patient-centered care. This participant identified losing her perception of patients’ personhood as she pushes to be fast and efficient. Realizing this now, she explains the importance of taking the time to talk with patients; “Sometimes you get so caught up in just doing tasks that you forget you’re dealing with people and emotions. So, you have to take that step back and it’s really hard to do because you’re so task-oriented on doing” (Nurse 9, 4147-49). This requires RNs to consciously act in good faith and be authentic to themselves. However, RNs also explain the negative impact time constraints have on their moral agency;

Nobody’s gonna think for you. Nobody’s gonna make that decision for you. So, you’re always thinking on the spot, you have to be morally aware when you enter our workforce. Because you don’t get to sit down and talk with somebody for 20 minutes being like ‘should I do this or should I do this’. No, it doesn’t work like that. We don’t have that time. (Nurse 9, 4407-11)

The pressures on the healthcare system appear overwhelming for the Novice RNs. They need to be moral thinkers from the beginning of their careers and have the ability for quick decision making in complex situations. The learning curve is steep and requires Novice RNs to adapt or else they will not survive in the healthcare system.

The consequences of these organizational factors are significant and may lead to moral distress, trauma, burnout, absenteeism and turnover; “The standard patient ratio is
2, maybe 3 and on average we’re getting 4, 5, 6 per nurse so there’s a ton of burnout and people are calling in sick because they just don’t want to be there” (Nurse 12, 6502-05). Ultimately, this organizational context puts RNs at risk of leaving the healthcare system.

I don’t know how people have been in (the) department for more than 5 years. I’ve been there for 2 years and I’m thinking of going part-time because of all the stuff that’s happening where you’re working short-staffed, you’re in charge, it’s not safe, it really gets to you, you get burnt out, you don’t get breaks, you haven’t even peed your whole shift, and those are concerns that everybody knows, CEO knows about and what’s happening? Nothing. (Nurse 16, 9329-36)

Nurse 16 explained that their workload is so heavy that numerous RNs are leaving. RNs are concerned about patient safety and feel burnt out. They feel their voices are not being heard as everyone within the healthcare system appears to know these issues while no solutions appear to be implemented. However, it is important to note that statistics on patient safety and accidents are reported and unit managers are held accountable if quality of care is decreasing. RNs may leave the system when they do not feel they are providing adequate levels of care, they get burned out; “Where I work, we have a lot of people leave and we’ve had a lot of staff turnover” (Nurse 1, 132-33). High turnover can increase the stress nurses face in their work. Understaffing creates frustrations which can lead to turnover: “understaffing is such a problem with the health region that people get frustrated and leave” (Nurse 7, 3175-76). Novice RNs explained that the system changes you, to survive in the system RNs must adapt or leave;

[There are] compassionate nurses who are starting in their careers for the totally right reasons, but within a few years because of the understaffing, budget restraints and all those things, they get burnt out really quick and become really bitter. Then you start to lose that compassion, and you lose the people who care and who want to do better. (Nurse 7, 3415-20)

Novice RNs begin their career and care for patients authentically by being compassionate. As they experience organizational constraints they can experience moral distress and
disconnect themselves from the work that they do leading them to change the way they see patients’ personhood. The system potentially loses compassionate RNs who want to provide quality care to patients.

Novice RNs cannot comprehend why more nurses are not being hired with all the overtime they work; “Every day, you could be working overtime if you wanted. But what is that telling you? You’re paying double, why don’t you hire more people?” (Nurse 16, 9363-65). To the system it is more affordable to pay overtime than to hire more RNs, however, it appears to lead towards a workplace environment where RNs are overworked, burned out and morally distressed. Long-term, it may be advantageous for the system to nurture an engaging organizational context where RNs have time, manageable workloads, and are adequately staffed.

All Novice RNs shared the toil nursing has on them, explaining it is physically, emotionally and mentally draining; “It’s exhausting, it’s emotionally and physically exhausting… and you can’t overdo it because you become resentful of going to work” (Nurse 17, 9641-42). Nursing is difficult and it comes at a price. Nurse 17 explains RNs have to be careful not to become resentful of the work and it could lead to feeling burned out. She goes on to say; “I don’t think it matters what nurse you talk to because they all feel that” (Nurse 17, 9636-37). All the Novice RNs explained feeling this way. It is also hard for Novice RNs to separate their work from their personal life; “They say not to bring your home to work and vice-versa but it’s hard, it’s really really hard to do” (Nurse 6, 2485-86). Nursing work impacts the health of RNs; “You go home with these crazy headaches because you’re wracking your brain all day, trying to help somebody” (Nurse 12, 6520-22). Nonetheless, Novice RNs explained that while nursing is difficult, it is
rewarding because they make a difference in peoples’ lives; “It’s high burnout, high everything but at the end of the day, it’s a very fulfilling job, you go home and you feel like you made a difference” (Nurse 13, 6966-68). Nursing is a demanding career, to be a moral agent it is important for nurses to find meaning and make a difference for patients.

4.2.2 Staffing, Workloads & Time: Expert RNs “Keep going”.

Even though Novice RNs work in the same organizational context as Expert RNs, they respond to it differently as they are confident moral agents and have developed the ability to keep going. Expert RNs remained in the nursing profession because it is their passion; “There are days everybody feel they're trudging through the war zone. But it's just my passion, it's what I absolutely love doing” (Nurse 19, 10249-50).

Expert RNs have the ability to see how the healthcare system has changed over the years. According to the participants, the current healthcare system is under increased pressure with more patients and complex care needs. To demonstrate the context of healthcare from a historical perspective, Expert RNs explained the increase in acuity and complexity over the last several years. This is demonstrated through statements such as;

In long term care, we used to have nice little men and women that were mostly pleasant, that just landed in our laps, with typical health needs. Now, it’s not like that at all, it’s much more complex. . . .we get a lot of patients who are really better off in the hospital and because the hospital reaches its capacity, we get them before we feel that they’re ready to come to us. And we get a lot of more complex cases, a lot of stuff that would have stunned us 18 years ago. Medically, we have things that are a lot more acute, we’ve had people straight from ICU, and things that really are not fair to us or to them because our nursing ratio is not to do this kind of acute care monitoring. (Nurse 8, 3523-35)

In the last two decades patients’ health needs have become more complex and acute in long-term care. It is unfair to the patients and to the RNs as they are not equipped to address
patients’ complex health needs and this can potentially decrease patient safety; “People are sicker. We used to do surgery on people, keep them for five to seven days now the same surgeries are going home the same day. So [for] the nurses the workload is huge” (Nurse 20, 10653-55). People needing the healthcare system have more complex care needs and than in the past. Maternity and day surgeries are examples discussed by Expert RNs where patients used to stay in hospital for days and now are discharged quickly. Other Expert RNs mentioned there are more and more people using the healthcare system. As a result, this can increase the workload on RNs and an unfortunate result is that RNs may take less time for patients.

We take less time for people. . . in long-term care, we have gone from trying to make our units smaller and with lots of activities for the residents to areas that are now bigger with less activities. . . The changes are an effort to keep the system moving, we've lost the purpose for the system which is to take care of people. (Nurse 14, 7439-64)

Over time, budget cuts to healthcare have increased the focus on saving money leading to changes meant to increase efficiency and effectiveness. However, in doing this the system risks being unable to meet the physical, mental and emotional needs of patients. The current system is more efficiency driven, focused on patient flow. Nurse 14 explains how this transition occurred; “It's not because somebody sat down and said 'we're gonna focus on money' but yet, the reality is that as you focus on money, you lose your focus on people” (Nurse 14, 7474-77). The institution of healthcare itself is not at fault, this reality slowly emerged because of budget cuts and focus was put on saving money, increasing efficiency and effectiveness. There are tensions between the values of the system specifically between productivity and patient-centered care.
The current context of the healthcare system can be illustrated through the organizational factors potentially leading nurses to be overwhelmed. Expert RNs expressed being so understaffed that they often stay late; “we are so understaffed…we’ve been working short, you work your day, there’s nobody to come in for evenings so you stay for evenings, so you do 16-hour shifts” (Nurse 15, 8588-90). Nurse 3 agrees, we are “very understaffed… We’re always working short, I’m always offered overtime to a point where you’re like ‘I need days off’ or extending your shift” (Nurse 3, 981-83). Further, Expert RNs explained feeling responsible for the Novice RNs, at times they stay late to help them;

I was one of those nurses who just could not allow myself to leave shift knowing what mess was going to be left behind… so I was staying two hours late or if I managed to get my work done, there was that young nurse across the hallway who was struggling. And I was constantly getting called to come help out. (Nurse 11, 5614-20)

Expert RNs feel responsible for Novice RNs. They also explained that patient ratios were higher when they started their careers. The pressures and urgency of the healthcare system led to growth and learning. To survive in the healthcare system, it was necessary to adapt as it changed;

Back when I started, the nurse to patient ratio was pretty much twice what it is now. . .but you learn and you grow and you have no choice, you have to survive because or else, you need to go somewhere else. And I survived. (Nurse 8, 3468-74).

In the end, in order to remain in the profession, she adapted. This Expert RN takes pride in having overcome these difficulties as it means she survived. It is important to notice the word survive as it demonstrates the intensity and pressures of the healthcare system. Expert RNs further expressed that while managers do their best, when it comes to staffing needs, their hands are also tied.
Our management for the most part is supportive of what we express as our needs for staffing, but sometimes, their hands are tied because ‘this is the allowance that we’re paid to fund you for’ and . . . there’s just nowhere you can go.
(Nurse 8, 3560-67)

Because of structural financial constraints RNs feel they have no where to go to express their staffing needs. Being short-staffed can negatively impacts patient care; “Short-staffed is hard because anytime you're short-staffed, your patient care suffers” (Nurse 14, 7939-40). RNs are concerned for patient safety, they want to provide quality care, but are constrained by the organizational context they work in. As explained in the previous section, these findings are similar to the experiences of Novice RNs whose health suffers when working short staffed. Expert RNs’ health also suffers by working in these circumstances as RNs work when they are ill and feel guilty for calling in sick;

Your whole focus is on taking care of others and where the struggle comes in is when you’re not feeling well and if you phone in sick, then you're going to make that unit short-staffed. So, you keep working even though you may be tired or you may not be totally healthy, and you just keep going. (Nurse 14, 7991-95)

The idea to “keep going” comes up often when discussing the organizational context of the healthcare system. To survive in this demanding environment, RNs put their physical needs aside and keep going to meet the needs of patients. Further, Expert RNs explained they forget to take care of themselves; “we sometimes forget to look after ourselves. . . I've gone a whole 12-hour shift without peeing and then had a bladder infection.” (Nurse 20, 11303-18). Others have had similar experiences; “I had taken so much overtime even though I was sick. . . managers would be calling saying ‘we have no one can you please come in’ and I would come in because I felt it was my duty” (Nurse 11, 5700-03). Having a sense of duty towards patients and managers allowed this RN to “keep going”. However, in the long term she suffered and became ill, ironically putting her own health at risk to
respond to the health needs of others. Nurses are expected to perform in a challenging organizational context that can impede moral agency and lead to moral distress.

Thinking of all the nights that I stayed up all night long worrying about my shift because I worked so hard to try and get it under control. I very well know why I was so sick. . .I did it by conscience, by guilt. But just to know that I probably could have been healthy until retirement if I would of been nursing thirty years ago, it hurts. It actually hurts. You feel betrayed. (Nurse 11, 6181-90)

The pressures of the system have changed drastically in the last decades and according to Nurse 11, she feels betrayed. She sacrificed so much of herself for patients and the system, it hurts knowing that nursing decades ago she would not have had to push so hard to “keep going”. Knowing the conditions RNs work in now provides an indication of why there is little trust in the healthcare system; “Now kind of gives you an indication as to why. . .everybody started fighting, mistakes were made, patients fell through the cracks, and people died for no reason” (Nurse 11, 6095-98). RNs in the system are under pressure to perform in a demanding organizational context that can negatively impact their moral agency and lead to moral distress. As discussed by Novice RNs, Expert RNs also feel the pressures of the healthcare system. There is no time to reflect on an adverse event; “If you have a patient load, you can’t just go home and sit down and cry. You have to keep going” (Nurse 2, 671-72). Doing this requires RNs to turn their emotions on and off, “I don’t get too emotional too often. . . You can’t just be blubbering through your whole entire day” (Nurse 2, 674-75). In having to “keep going” nurses cannot become emotional as it would interfere with their work and patients who need them. This can be a source of moral distress as RNs need time to process situations and their emotions. To overcome these feelings of distress, Nurse 14 explains that; “not every day goes perfect. . .but on those days, you still have to go to work the next day, and you still have to plan to do your best”
Further, an organizational context where RNs know what needs to be done, but they do not have time to provide it can potentially lead to moral distress. For example, long-term care nurses may not have sufficient time to spend with families making difficult end of life care decisions.

They may not have the time, they may know what they want to do, but there's not the time to do it. In long-term care, you needed to take time to help families feel confident with all the emotions and the decisions they were having to make on behalf of their loved one. And they needed somebody that they could trust and talk to and so when I took out the time to talk to them [families] that was probably time where I should have been sitting down charting... And now, if you, as a staff member, go 'I have these many people's pills to do, these many dressings. I'm sorry, I understand you're in this impossible dilemma, but I've got 2 hours’ worth of work ahead of me, and all I can do is smile at you and say good luck.' So, it is difficult for staff nowadays. . . you have significant things you have to deal with, and you don't have to time to sit down. (Nurse 14, 7531-52)

For RNs, there is an impossible dilemma between being efficient in providing care versus taking the time to talk to families and patients. RNs encounter significant events, but do not have the time to sit down to process them. This can be a source of moral distress for RNs who strive to be authentic in their work and have their voices heard by talking with families. In the end, RNs should question themselves on the care they provide; “Did I do my job or did I give care? because I can't give both. . .you need to be able to look at that day and go "did I do my best?" (Nurse 14, 7560-61). Questioning oneself may help RNs prevent moral distress as it allows them to be aware of their choices and responsibilities towards patients. To provide care centered on the personhood of patients and their families Nurse 14 stayed late at work often. For her being able to help families was significant and
it meant sacrificing time she had with her own family. To put this reality into perspective

Nurse 8 shared a powerful portrayal of nursing in the healthcare system:

> It’s really hard work and your heart gets involved and you can’t help it. So, they cry, I cry, and we lose someone, we shed tears. We struggle. We put a lot of miles on our legs, we put a lot on our backs, on our shoulders, and it’s a heavy responsibility, physically, mentally and emotionally. It comes at a price. (Nurse 8, 3977-81)

Nursing is emotional work, in caring for patients and their families, RNs are touched by their patients and grieve too. Nursing is a heavy responsibility in all aspects; physically, mentally, and emotionally. However, Nurse 8 specifies that nursing comes at a price, for some RNs they become ill, burned out, and experience moral distress.

### 4.2.3 Novice RN’s Perceptions of Administration

The healthcare system operates as a bureaucracy attentive to cost-saving measures increasing efficiency and effectiveness. Over time Novice RNs believe that the system has become institutionalized; “the culture of the healthcare system is very institutionalized” (Nurse 4, 1740). Novice RNs suggested the need to foster a workplace context where care is centered on patients rather than driven by cost-saving measures. They perceived a gap between frontline nursing and senior management. While both Novice and Expert RNs shared numerous similar concerns, the findings demonstrate that Novice RNs appeared to be increasingly more overwhelmed by their perceptions of the administration than Expert RNs.

From the perspectives of Novice RNs, the healthcare system is institutionalized, and some of these nurses suggest that they are not included in the decision-making process. They suggest that they are not empowered to be moral agents in the bigger picture of
healthcare; “It’s [healthcare] institutionalized, it’s hard because the people sitting in offices, they don’t really ask the front-line workers what needs to change... we don’t have a say in what we need” (Nurse 5, 2212-14). Nonetheless, it would be unfair to blame administrators of systematic errors. Some participants suggested that there are avenues for Novice RNs to have their voices heard such as through union representatives, meetings with their association, workshops, and conferences.

Below are examples where Novice RNs suggest being disempowered. While reading these statements it is important to understand that the Novice RNs are beginning their journey to developing their voices.

When it comes to administration and policy, we get very frustrated because we know what needs to happen to improve our patients’ health, but yet our managers are tying our hands or the government is tying our hands. So overall, on the day to day, yes, we make the decisions and we have the control to work with the patients to the best of their ability. But when we want to push it a little further to get them into a different situation or to improve their health on another level, that’s when we’re tied. (Nurse 7, 3033-41)

Novice RNs perceive senior management in healthcare to be tying their hands. They would like to respond to patients’ needs in a more significant way. Other Novice RNs also agreed, Nurse 16 shared an exemplar demonstrating how she experiences healthcare’s normalized workplace context.

The norm, now, is to work short-staffed, that’s the culture. There’s more people that are sick, but they haven’t hired any more new nurses. It’s normal to have 20 people in the waiting room, the department’s full, the hospital’s full, there’s nowhere for these patients to go, but that’s normal and we deal with it... Nurse-patient ratios is too high and it’s not safe for patients and that’s becoming the culture and the norm for our healthcare system and it shouldn’t be and it’s just gonna get worse and worse and worse. Because more often than not, we’re so busy that we don’t even get breaks... At the end of our shift, we debrief and ‘has anyone had supper, did you even eat?’ We’ll eat on the go but ‘have you even peed today?’ We don’t even pee, not even once. We don’t have time to stop and pee, we won’t drink anything because we don’t have time to stop and have a drink... I think
everybody just gets burnout. You need a break. You need to eat, you need to recoup, you need to reenergise your body, you need to take a moment to think, but you don’t get that in the hospital. There’s no room for any patients to go. There’s 20 in the waiting room and it’s like ‘oh my god, it’s so overwhelming’ and you just want to cry sometimes. It’s just painful to uphold. . . That’s so hard but it happens all the time, all the time. (Nurse 16, 9261-96)

Novice RNs experience significant pressures working in the new norms of healthcare. It has become the norm that hospitals are overcapacity and RNs have heavy workloads while being short staffed and experiencing time constraints. Nurse 16 explains that during their shifts RNs do not have breaks, sit down to eat, or take a moment to think. This is an environment that can impede moral agency and lead RNs to become morally distressed. The union and the provincial nurses’ association have work representatives that RNs can go to communicate their concerns. However, it is unknown how accessible this avenue is since it was not mentioned by Novice RNs. It is also important to note that patient safety statistics and accidents are reported in the healthcare system. Managers are held accountable if their unit’s statistics are unsatisfying. This realization can give hope to RNs and patients that while there are organizational constraints in the system, it is performing well and patients can receive successful care.

In addressing the context of the healthcare system, Novice RNs suggest that individuals in positions of leadership within healthcare should work a shift in their shoes to truly understand their reality and the challenges they encounter; understaffing, heavy workloads, and time constraints;

I think they [administration] need to work on the floor with the front-line to see how it is and to know what the front-line nurses go through. Because you see them behind their desks, they’re writing all these policies and all these suggestions and they’ll ask suggestions from nurses, but they won’t know exactly what’s going on until they get up from behind that desk and . . see what these nurses are doing and be on that floor. . .Before you come up with something new, be on the floor, be on the ward for a period of time, a longer period of time and know what needs to be
done. Know what the nurses’ concerns are, know what the struggles of the nurses are. . .They need to go out there and see exactly the frustrations. They hear the frustrations but they don’t experience the frustrations and for me, it’s all about the experience. They should experience it. (Nurse 10, 5132-62)

Novice RNs suggested that their voices are unheard, they experience the realities of healthcare, but are not the policy-makers. It is important to note the attitude Novice RNs have towards the administration resembles an ‘us versus them’ mentality, which is not conducive to creating positive change. Novice RNs want senior management to experience what it is like to be in the frontline. However, this is a vague recommendation as it is unclear who “they” is; there are multiple levels of administration in healthcare. It would be unfair to suggest that none of them have experienced the frustrations of frontline nursing. The statement below further explains the perspective of Novice RNs on this subject:

If you’re hiding in an office, you won’t know, you won’t see it, and you won’t understand what it’s like when someone just says ‘it looked like a murder scene, there was blood everywhere’ and they’re like ‘oh well, you’re exaggerating’ but to actually be there and experience it and see the pain and the suffering, what these people are going through, they don’t get it. And maybe, once upon a time, they had and that’s why they thought they could make a difference, but they lose a lot of that because they’re not involved anymore. They just do reports and deal with them that way. (Nurse 12, 6715-23)

Novice RNs want administrators to listen to their voice and experience the challenges they face. Novice RNs would like administrators to see the pain and suffering that they witness and experience in the frontlines. From an outside perspective Novice RNs could appear passive in attempting to communicate their concerns.
4.2.4 Expert RNs’ Perceptions of Administration.

Similar to the Novice RNs perceptions, there appears to be a gap in understanding the realities of the practice context between Expert RNs and the administration. Some Expert RNs’ suggest that administrators do not always understand how the system has changed in the last decades because of the increasing pressure on RNs in terms of patient load and complex care needs: “Lots of people who are working higher up, they were frontline nurses at one point. As farther away they spaced themselves mentally. They almost don’t understand anymore” (Nurse 2, 709-12). This context appears to be a potential source for moral distress among Expert RNs as they perceive that the administration does not always understand them. Nurses can always ask for help, but they need the support from administrators; “If nurses don’t ethically agree with something, they do have an avenue. They don’t have to do it but then you need the support of your management team” (Nurse 18, 10049-51). To have one’s ethical voice heard as an RN, support from management is crucial. It can be difficult to have this support if RNs perceive that senior management does not understand their realities and moral dilemmas they face. RNs expressed feeling supported when management is present; “all managers need to work the bedside or show their presence to get buy in and to get respect from the staff. The further you are away from it, you kind of lose perspective” (Nurse 20, 10959-61). Issues arise when management is not present because it may mean they are not connecting with RNs. The disconnect occurs because Expert RNs feel they are not on the same team as upper management;

The folks who are doing the front-line work, they’re so far away from the upper management that. . .They really have nothing to do with each other except that the ones in upper management make it so that they [RNs] have a
paycheck. But they’re not the ones giving the care, so I trust the people who give the care. (Nurse 14, 7504-10)

There appears to be tensions between the ranks of healthcare as each brings different perspectives and priorities to the system. Nurse 14 explains that she trusts the people who give the care; the RNs. She appears to see upper management in a negative way because of the organizational constraints she experiences everyday in her work. However, all healthcare workers bring something unique to the table, RNs and administrators are both valued in the system and should work together to resolve issues. An Expert RN explains that they can exercise their moral agency and communicate concerns; “I'm active in the union as well so that is another place where I feel I can put my voices forward” (Nurse 19, 10311-12). Another Expert RN also acknowledges that there are channels to be heard within healthcare such as conferences, meetings, and the union.

You use your voice on a regional level to build bridges, but as you go provincially, nationally and start attending more conferences and meetings and having input for the curriculum on a national level. . .you can make a difference with your voice right where you are and make a huge impact, so I was probably more one of them. It was only in the last few years that I’ve been going out to Ottawa to help redo some Canadian policies and procedures. . .so now, your experience is being used in a different way to impact new nurses coming up. (Nurse 18, 9993-03)

Novice RNs appear to struggle to see the avenues where they can exercise moral agency in the healthcare system. While the reason why is still unknown, it is important for Expert RNs and all levels of administration to work towards encouraging Novice RNs to communicate their concerns. Further, there are tensions between all levels of healthcare because everyone has their own priorities, however the focus should be on what brings the system together; the patients. Nurse 19 further explains that; “there's a lot more tension between the ranks of health care workers. . .because everybody is trying to do their own agenda” (Nurse 19, 10360-64). The reality of the current healthcare system is that it is
restricted by its budget. Patient flow is valued in an attempt to meet the needs of all patients efficiently. However, RNs may feel distressed when they perceive that they cannot provide patient-centered care. Nurse 15 further explains; “there’s a lot of great points for the healthcare system. But I think it’s more politically run so it just goes down the line because it’s all about money so what matters takes the backseat” (Nurse 15, 8687-90). Other Expert RNs agreed with this by explaining that if the final decision-makers are not healthcare professionals, they may not understand the needs and the realities faced by RNs. In the end, the perceptions of Expert RNs on the administration emphasizes a gap in understanding the realities of the practice context.

Nonetheless, the disconnect is not as simple as RNs make it appear. The language used by the majority of participants to describe levels of administration is not conducive to having a team atmosphere within all of healthcare. An Expert RN explained it is easy for RNs to say administrators need to have their “fingers in the pot”, but administrators also have high expectations put on them and encounter challenges in their positions.

I think it’s the culture of the healthcare system. They [administrators] get expectations put on them and it’s easy for me to say that they need to get their fingers in the pot, but looking at their desks, I know there’s high expectations on them and they’re handling stuff I have no idea about. (Nurse 8, 3907-11)

There appears to be a lack of understanding between the RNs and levels of administration. The organizational factors; staffing, workloads, and time impact moral agency and potentially lead to moral distress have led to a divide where RNs perceive they are not on the same team as the administration. Ultimately, it is important to note that “the big picture of the healthcare team still has fingers in the pot with the frontline” (Nurse 8, 3836-37). While it appears that upper management and RNs are their own disconnected entities, they are still one under the umbrella of healthcare. In the big picture, the administration does
have their “fingers in the pot with the frontline and their goals are to improve the healthcare system for patients and for RNs.

4.3 Theme 2: Growth of Moral Agency: How RNs develop voice

Novice and Expert RNs have different voices in the healthcare system. Novice RN participants perceive that they do not have a voice in the healthcare system beyond providing immediate care to patients. This troubles them as they strive to do more to improve the health of their patients. Similarly, Expert RNs recall feeling that way at the start of their careers, they explain that it took time for them to develop their voices and be heard within the healthcare system. To further understand the moral agency of RNs it is important to look at its development over time and to question; how do RNs develop their voices?

4.3.1 Novice RNs’ Voices in a Bureaucratic System.

The voices of Novice RNs in the healthcare system varies significantly than the voices of Expert RNs. Novice RNs feel they are not free to talk about their concerns as compared to Expert RNs;

You feel very judged if you say anything about your profession. Older nurses will say ‘just say things! Speak up!’ but it’s like ‘you are on your way out of your career and I admire everything that you have done and the courage you have to speak up but I’m just starting.’ I have a few more years left and I don’t want to make it more difficult than it needs to be. (Nurse 7, 3328-33)

Novice RNs are cautious in how they express themselves. They struggle to exercise their voices as they are less experienced and will not speak up the way Expert RNs do. Nurse 7 explains the nursing profession is difficult enough without feeling judged if she speaks out. Other RNs, explained that they can voice their concerns to their team, but they do not
feel like they have a voice on a larger scale. Nurse 17 explains; “we have huddles around the day so we can voice concerns … whereas, as a whole, if I was thinking nursing on a bigger scale, I don’t think I have a voice quite yet” (Nurse 17, 9543-45). Novice RNs perceive that they can voice their concerns in a practice context, but not necessarily in the big picture of healthcare. When asked what limits her voice Nurse 9 suggests that they are simply not allowed to have an opinion, they walk on eggshells;

We aren’t allowed. We aren’t allowed. They tell us no. We have a gag. If I say something, I could lose my job or I could be charged. So, I don’t get to have an opinion. They tell us we’re allowed to have an opinion and we should have an opinion but I don’t have an opinion. (Nurse 9, 4300-04)

Novice RNs are scared that if they speak up, they could lose their job or face repercussions. Expert RNs may say they should have and voice opinions, but Novice RNs feel voicing themselves puts them at risk. However, it is important to note that there are policies in place that require staff not to speak on the behalf of the healthcare system or hospital. This is the same for every profession whether a teacher or a government employee. Nurses are required to operate within this policy. As beginners in their careers, it is understandable that Novice RNs; “are frustrated and angry but they’re also scared to say anything. We want to advocate for our profession and we want to advocate for our patients” (Nurse 7, 3309-11). Novice RNs want to be moral agents, but they are scared as they are in the process of developing their voices. Additionally, Novice RNs can have an increased difficulty to be moral agents in an overcapacity environment such as hospital;

When I was at the hospital, it was; ‘this is your routine, this is your schedule and this is what you do’ . . . Being that it’s such a fast, overcapacity environment, there isn’t much you can do beyond your day-to-day. (Nurse 7, 3062-67)

Novice RNs explain that the organizational context of the hospital does not empower RNs to be moral agents for their patients. The overcapacity environment can require RNs to be
task-oriented. Novice RNs explained that in everyday work they have a voice in taking initiatives and managing immediate care for patients. However, it is difficult to be a moral agent when facing organizational barriers. In the big picture of healthcare system, they do not feel their voices are heard;

It is heard in the fact that if I need immediate care, I can go to one of the physicians that works in emergency, tell them what’s going on with the patient and get things done in that way but for the bigger picture, I don’t think that it’s heard very well. (Nurse 16, 8815-18)

RNs can take initiatives for patient’s immediate care, and have their voices heard by their team. However, there are often situations where they would like to do more for patients, but their hands are tied; “There is a lot of ‘your hands are tied.’ Like you want to do so much more but you just can’t” (Nurse 7, 2966-67). Nurse 12 explains that to avoid patients’ care falling through the cracks, she focuses on having her voice heard with her team because they can directly impact patients together;

There’s not a lot of voice for nurses. We can voice it but sometimes, we’ll get told we’re wrong… You’re better off dealing with your team than dealing with the higher-up. Because the higher-ups aren’t actually dealing with front-line nursing anymore. . . But if you just sit there and cry about it, the higher-ups won’t do anything because they don’t know, they don’t know anymore, they may have lost that piece of their nursing because they don’t do it anymore. It’s all paperwork and desks and dealing with bigger issues. I don’t feel that nurses have a huge voice. We have a huge part when it comes to the care but when there’s everything going wrong, I don’t think our opinions really matter and we’re the ones that see it and experience it. (Nurse 12, 6690-06)

Novice RNs make up a large portion of RNs, it is concerning that such a large group feels like they have such limited power in the system in which they work. In the statement above, it is unclear who are the “higher ups”, which level of administration is targeted. The opinions and concerns of RNs are important and valued, therefore, they should be communicated with the union and the provincial nurses’ association representatives. The
relationship between Novice RNs and senior management should be fostered to improve the development of Novice RNs voice.

4.3.2 Expert RNs’ Voices in a Bureaucratic System.

Expert RNs expressed their journey to finding their voices in the bureaucratic healthcare system; “When you’re young, you don’t know what mold you have to fit yourself to but as you get older, you realise, I work better as me than as another person that nobody knows” (Nurse 2, 684-86). As time passed, Nurse 2 learned to be herself in her work. At the start of her career, Nurse 20 felt afraid to use her voice, she says “that's the beauty of getting older, you tend to speak your voice more, but I remember when I was younger not speaking my voice just because you are afraid to rock the boat” (Nurse 20, 11155-58). This sentiment resonates with what Novice RNs are currently experiencing. At the Novice stage, it is difficult to be a moral agent as RNs are learning the organizational structure of healthcare system.

The pressures of the system also had an impact on Novice RNs becoming Experts. Nurse 18 shared her story which demonstrates the typical development of a one’s moral agency. At the start of her career, she had no confidence to speak up in her work, after five years, she noticed people looking up to her for guidance and assistance. This led her to feel responsible for others, but also feel like an imposter in her profession. As she grew she became more aware of her role in the larger picture of healthcare;

My first several years, no confidence whatsoever, would never ever speak out about anything. So that would last for your first 1 to 5 years, and then after that, people around you start looking to you for guidance, assistance and input, and you start to give it. But inside, you start feeling ‘I’ve got them all fooled. They think I’m better than I am’ but as you grow and mature, you see more sides, you see your own area where you work as part of a bigger pie. (Nurse 18, 9981-88)
This shows the extent to which RNs moral agency grows in their first five years as RNs. It is important to notice that the pressures of the work in healthcare perhaps helped her develop her confidence as a moral agent. Nurse 8 also has a similar journey;

When I first started, as soon as I saw the building, I’d be in prayer ‘Oh Lord, oh Lord, help me not kill anybody, help me be wise and make me aware of what I have to do to be successful today’. I don’t have those same kinds of prayers but there’s still days there’s lots of trepidation. With the time, fortunately or unfortunately, you gain seniority and now, I’m one of the more senior nurses and with that comes experience, you’ve seen a lot of stuff, but also comes expectations, you’re supposed to be the one who knows what to do in situations and you don’t always know what to do. So, we try very hard to work as a team and to tell other team members that you’re not alone, there’s other nurses, you might be alone for 5 minutes but there’s other nurses in the building and you must call them and ask if you don’t know and even with seniority, its okay to not know. That’s something we tell new nurses who start out with us, you might feel alone but you’re not, you have to reach out, you have to ask. (Nurse 8, 3490-05)

As RNs transition from Novice to Expert they may be apprehensive and scared. In striving to survive in the system, Nurse 8 grew in her career. Expert RNs are expected to be wise and guide other nurses. This can be stressful which is why she states the importance of working as a team and asking questions to other nurses. All Expert RNs noted the importance of asking questions; “never be afraid to ask questions” (Nurse 20, 10786). Providing this support can make the difference for new RNs as it encourages them to develop their voices. With 35 years of experience, Nurse 18, has become a strong moral agent, she feels that as a nurse “you can make a difference with your voice right where you are and make a huge impact” (Nurse 18, 9997-98). She emphasizes that nurses can use their voices to make differences in healthcare. As a seasoned nurse she uses her voice to impact the younger generation of RNs as she believes “if you’re impacting new nurses, you’re impacting the quality of healthcare” (Nurse 18, 10003-04). As a moral agent she
exercises her voice in encouraging younger nurses as she believes impacting them will improve the quality of healthcare for patients.

Other Expert RNs also discussed the importance of being moral agents. If they do not think morally it creates a gap between patients, families and higher levels of healthcare. Nurse 14 says if RNs were not moral agents “there would be nobody else to stand in the gap between patients, residents, families and the decision-makers who are higher up” (Nurse 14, 7868-69). It is crucial for RNs to be moral agents in their work as they facilitate the moral conversations needed in caring for patients. Through moral agency RNs may improve the quality of healthcare by acting as a bridge between the system, patients and families. Nonetheless, Nurse 8 explains RNs are encouraged to be moral agents only to an extent. RNs can encounter situations with patients that distresses them, where their voices appear not as valued as other members of the healthcare team. The exemplar below illustrates an ongoing ethical dilemma encountered by Nurse 8 where she experiences moral distress and where her voice is unheard.

I do think nurses are encouraged to be moral thinkers to a point. . . .We have a case of a resident who they’ve never been a nice person since we’ve had them. They’ve been very resitive, very angry since they’ve come to us. I think when they first came to us, had they been agreeable, a lot of pain medication and a little bit of antipsychotic medication would have changed their lives. But they refused and refused and refused and this person who was difficult to care for at the start, is over-the-top difficult to care for now. They will refuse to be changed for days and days and days so they’ll be lying in a urine-stained diaper for days and days, stool in their diaper, vomit in their bed, and this resident screeches, yells and swears at us to a huge extent. And we’re told to walk away because they have a right to make a decision as to whether they receive care or not. So, then we’re left with a resident who looks bad, smells bad, acts bad, and who is at a risk of having a broken-down bottom and all that. So that’s a big dilemma. That’s something that weighs on us very heavily. We’re told to walk away because we don’t want to do something to them but everything within us is saying ‘we have to clean them up, we have to provide right care for them’. We don’t have an answer to that yet. It has gone to the ethics committee and we don’t have an answer because we don’t know what to
do. So, in that respect, sometimes we need to think on the moral situation in a deeper way and sometimes we have moral situations that trouble us deeply because we have an instinct for care. (Nurse 8, 3915-52)

In this situation, Nurse 8 feels moral distress because her core values as a nurse are conflicting with the patient’s right to refuse care. RNs have a strong instinct to care and seeing this patient do this everyday is morally distressing. The patient’s refusal of care creates an unsafe and unsanitary work environment for RNs. Further, Nurse 8 questions the competency of the patient, but they are deemed competent by a psychiatrist. She comments that this psychiatrist spends little time with the patient. She feels her voice is unheard and it is creating moral distress as these issues concern her deeply.

Is this person competent to be making their own decisions? So, you get a psychiatrist coming in and having a little conversation with the person and they say ‘oh no they’re competent’ and we’re like no, you can assess this person for 15 minutes and say they’re competent or you can live with them for 5 years and say no, we’ve seen this and this, they’re not competent. So those are issues that concern us deeply. (Nurse 8, 3957-63)

Hierarchy is present in the structure of the healthcare system. Through this situation, it appears that the concerns of numerous RNs are disregarded because of the decision of one psychiatrist. The ethics committee involved also does not know how to approach this situation. It is deeply distressing for RNs to experience this situation over and over again while no one seems to have a solution. Nurse 8 has observed this situation, made assessments and recommendations, but nothing changed. RNs are told to be moral agents, yet when they assert their voices, no actions are taken. What does this do to the morale of RNs? It perpetuates a climate of moral distress and an understanding that RNs’ moral agency, whether Expert or Novice, is limited by the culture of the bureaucratic system they work in.
It is essential for RNs to be moral agents so they have the ability to tailor their care to meet the needs of each patient. However, RNs experience moral distress when policies do not meet the realities of patients. The exemplar below demonstrates such a situation:

We’re all faced with situations where we don’t follow the rules because the rules don’t reflect what we feel about the situation … I’ll give you an example that happened recently. The unit I work on, it’s people who are medically more challenged, but mentally, a lot of them have a really great memory and they want to be responsible for the care they are choosing. So, there’s this evening shift where the nurse has to go and give them their evening pills and that shift got shortened, the hours got changed. And there’s 2 residents who don’t want to take their pills in that period of time. So, they’ve said to the nurse ‘leave my pills here, I’ll take them later’. And there’s experienced nurses who know these 2 residents and will say ‘I trust you, I’m only giving you Advil and laxatives, so I’m gonna leave your pills here because I trust you and you have shown we that you still take them’ even though the law says you can’t do that. So along comes this nurse who has not practiced for very long and she refuses to do that. She got very upset and told the residents ‘I can’t do that, you have to take your pills now, in front of me, I demand that and there’s no way I’m leaving your pills for you to take’ to the point that the resident feels disrespected and so belittled that the next day, they’re in tears and they say ‘I don’t know what to do, this nurse wouldn’t give me my pills and I know what I want and I know what I should have so what’s gonna happen tonight? Because I really don’t want to take my bedtime pills until 9pm and you’re asking me to take them at 7h30’ and the manager comes in and says ‘the law says the nurse can’t leave your pills so she can’t leave your pills.’ But those of us older nurses are gonna leave their pills. So that’s an example of that. The moral issue is to not leave pills unattended. That’s a fact of nursing, a law of nursing, but does it serve that person? Not at all. It doesn’t represent, it doesn’t suit them well, and it doesn’t suit their knowledge. There’s people we wouldn’t leave their pills. It would be stupid to leave their pills but for those 2 people, our gut tells us that, and our heart says do and the law says don’t. It’s a little thing, but it ruined their day, for days and days. . . [The residents] that’s one thing they have control over, when to take their bedtime pills. They’ve lost control over everything in their life and this is one thing they still had some autonomy and the rules say no. (Nurse 8, 4031-72)

In long-term care RNs can have strong relationships with patients as they spend significant time with them. In this situation, the Expert RN sees the personhood of each patient and understands their abilities. The relationships were built overtime, and trust developed. However, policies do not account for this relationship, and they do not consider the moral agency of the RN. In the exemplar above, there is a clear distinction between the practices
of the Novice RN compared to the Expert RNs. The less experienced RN does not see the impact this situation has on the patient. She has not integrated the various ways of knowing, therefore she does not see that the policy does not accommodate the patient. The Novice RN may fear the policies, however, the Expert RN understands the context of care, she wants the patient to feel respected and accord them autonomy and control over their care. For the Expert RN, the moral issue is not whether or not the pills should be left out, it is that the Novice RN does not see the personhood of the patient and that is troubling for the Expert RN. However, why cannot the patients have some control over the structure of their care? The Expert RNs understand this and have the ability to integrate the various ways of knowing to make the best decision for the patient.

An important difference between Expert and Novice RNs concerns moral agency enacted through patient relationships. It is difficult for Novice RNs to develop these connections when they are attempting to adapt to working in the system’s organizational context. Over time Expert RNs have found ways to maximize their connections with patients. For instance, RNs in acute care explain that they strive to make meaningful connections with patients in the short time that they are together. RNs in long-term care explain a meaningful part of their work is centered on creating a long-term bond with patients to provide therapeutic care. This connection potentially increases the quality of care patients receive. However, because of the structure of the system it can be difficult for RNs to develop a relationship with their patients. It is up to each individual RN to make the patient’s personhood a priority and create a therapeutic relationship with them.

Expert RNs in acute and long-term care explained the importance of forming a relationship with patients. Having well-developed relationships with patients is an
expression of moral agency in nursing as it encompasses advocating, understanding the patient’s needs, being compassionate, and taking initiative. By having a therapeutic bond with patients, Expert RNs act in good faith and strive to be authentic by living their caring nature in their work. Expert RNs voice the meaning of having a strong connection with patients as patients engage in their daily living and in their dying. It is apparent that the ability to integrate various ways of knowing is essential to have a successful relationship with patients where they receive a high level of care physically and emotionally.

In acute care, Nurse 20 finds meaning in taking care of patients and their families. To her it is a gift as she becomes part of their journey; “rewarding nursing is getting to know those people and families. It's a gift they are giving us. We become very much a part of their personal story, their personal space, they are allowing us to help them” (Nurse 20, 11288-90). This Expert RN respects patients and appreciates their personhood; it is a privilege for her to care. Nurse 19 also explains that her relationships with patients are meaningful even when they are limited by time; “as short as it may be there's definitely always a relationship there” (Nurse 19, 10274-75). In long-term care, an Expert RN shares a beautiful exemplar of having a meaningful connection with a patient. Nurse 8 takes care of a vulnerable elderly patient suffering from dementia. It is important for this Expert RN to be a safe person for this patient, so she has taken the time to create a special bond with her. An expression of moral agency is having the ability to develop close therapeutic relationships with patients, the exemplar below is an ideal illustration of this as well as the art and esthetics of nursing practice.

There’s a resident on my unit who’s very lost in the world of dementia. She can talk, but nothing that’s coming out of her mouth makes sense. And I’ve made it my goal with her to get into her space and be a safe person for her. So anytime I go
past her, I stop and I get really close to her face and I look at her in the eye and I call her by name and we laugh about something. We giggle, and I often don’t know what we’re laughing at but she often thinks something is funny or worth experiencing together so we sit there in our little bubble and laugh about something. When I walk into the facility and I haven’t been on for a while, and I greet her in the morning, her hands fly in the air and she recognizes me. Her face lights up, and it’s like ‘I haven’t seen you in forever, where have you been?’”. She doesn’t know my name, she’ll never know my name. Along with that comes being able to give her pills successfully. It doesn’t seem like a big deal but some nurses, they go up to her quickly, they crush her pills and they put them in pudding, because we do that with people, and she turns away, she gets grumpy, she puts her head in her hands because you’re forcing her to do something. I go up to her, I sit forehead to forehead, and I call her name and she smiles. I show her the pills and I ask her if I can help her and so I take the pills a couple of times and she puts them in her mouth and swallows them and I applaud her success and she laughs and I put the rest of her pills in her mouth and she gets them down and I tell her how amazing she is and I’ve got the pills into her successfully for another day. The importance to taking time and treating her as a person and finding her safe zone where she feels it’s okay and I’m okay. The key to successful nursing is favour, personal favour. (Nurse 8, 3773-99)

In this exemplar the Expert RN has a well-developed relationship with her patient and this has given her in part, the ability to give her medication successfully. She sees the patient’s personhood and takes time to treat her as a person. She describes other nurses attempting to force this patient, but that is disturbing to the patient emotionally. She explains the key to successful nursing is giving personal favour to each patient, to meet her unique needs.

Similarly, Nurse 15 explains she has a close relationship with patients and also their families in her line of work:

You get to know their family, it is giving end of life care… you get super close with them to the point where you almost cross the line a little bit. They want to know all about you and you’re supposed to not do that in nursing. (Nurse 15, 8266-73)

As an Expert RN, she understands in what contexts she may cross boundaries. She does this to provide a high level of care physically and emotionally to the patient, and also to
the family. By doing this she is showing compassion and integrating various ways of knowing. However, RNs should also protect themselves from experiencing moral distress, this is why she states that they are not supposed to cross the boundaries as nurses.

In the exemplar below an Expert RN shares the impact of having long-term relationships with patients. She has a sense of familiarity with patients allowing her to have a deep understanding of their needs in daily living, but also in their dying.

There’s some residents that we’ve worked with for years so we know a normal day for them and a not normal day for them because they have become a part of us. . . we’ve got that familiarity so it makes the assessments easier but nothing is ever predictable in healthcare either so, it requires you to be very independent so in that moment, if something critical happens or if something changes in a large way, it rests on you. We are huge advocates for our residents, in their daily being but in their dying as well, it requires us to really push forward for comfort measures in the end and our voices have to be loud and our voices have to be strong because in the end, that can make the difference between a very difficult death and an easy death and that’s something we take very strong pride in and we’re very passionate about end of life care and that might mean the inclusion of how much nursing care is needed for them or how their pain is being managed or when to say enough is enough and to have difficult conversations with the family and to say "you know I think we need to let them go, or pull back, or make sure to get your family here’’, those are times we need to be very strong. We can see that more than a doctor can, because a doctor can come in and say ‘‘they’re not responsive, it’s gonna be any day now’’ and we actually know that they haven’t been responsive for 3 weeks and nothing’s changed. There’s things we can see because we have a long-term relationship with them. (Nurse 8, 3730-55)

This Expert RN is a moral agent for her patients, she has integrated various ways of knowing what it takes to respond to her patients’ health needs. She explains that healthcare is unpredictable and this requires you to be independent. When critical events occur, it rests on nurses to take initiative. The Expert RN shares the disconnect between how nurses and physicians see patients. Having a well-developed relationship with patients in long-term care is crucial as it enables RNs to be advocates for patients in their living, but also
in their dying. This exemplar is a clear case of the expression of moral agency in nursing through relationships. RNs take pride in and are passionate about end of life care because they share great concern for their patients. They understand moral principles and use them to guide decisions and in this case this means advocating for comfort measures and having difficult conversations with families. It is in these difficult situations that RNs must be strong and effective moral agents.

Expert RNs also explained the key to successful nursing is recognizing the signs of distress among patients. Expert RNs recognize the importance of having strong listening and observational skills. Having the ability to recognize signs of distress in patients is key to providing successful care. Nurse 18 explains;

> You have a huge role to play in advocating for your patient. What’s even more important than what you’re doing is what you’re seeing. Gut reactions are important, being able to recognize when your patient’s status is changing. . .that’s how you can make the best difference. (Nurse 18, 9724-29)

This Expert RN is indirectly talking about her moral agency through discussing the importance of being observant and being able to make quick decisions to provide the best care possible. In using her moral agency this participant is advocating, protecting her patients and providing a high level of care. Similarly, Nurse 15 explains that nurses have to learn to follow their instincts having integrated the fundamental ways of knowing; “you gotta follow your gut feeling because sometimes, it’s just your gut feeling and there’s tons and tons of policies . . . [But] you have to go with your gut” (Nurse 15, 8480-83). She explains there are policies in place however, they may not always apply as healthcare is unpredictable and intense. This environment requires nurses to follow their instincts to provide the best care for patients. Nurse 14 also explains the importance of being observant as it allows nurses to understand details that may not be explicit such as pain. She says;
“Listen and observe because if you don't have good listening skills and good observational skills at the same time, you're going to miss the person who may not be asking you for pain pills but who is in pain” (Nurse 14, 7790-93). Expert RNs emphasize the skills that have allowed them to provide successful care. Through their years of experience, they learned to integrate various qualities leading them to become moral agents for their patients.

4.4 Theme 3: Moral Agency and Moral Distress in End of life Care

End of life care represents an area where the context of the organizational culture, moral distress, and the moral agency of RNs interact. Various factors such as the structure of advance care directives and family dynamics can impact RNs’ voices and also increase moral distress. Through end of life care, Expert RNs integrate various ways of knowing to be moral agents while Novice RNs are in the process of learning to do this. In the current system, RNs have an unclear role in moral conversations, often getting caught in the middle between patients, families and physicians. Expert RNs appear to focus on providing emotional support to the family whereas Novice RNs are still learning to do this.

4.4.1 Moral Agency and Moral Distress in End of life Care: Novice RNs.

Novice RNs find their work in end of life care fulfilling as they are with patients in their last days. They become important to the family and that gives them the ability to make a difference in peoples’ lives.

When I used to deal with palliative care, when people die, it was actually pretty fulfilling because you got to be with people for their last day of their lives. For the most part, you’re really important for the family, and you’re really important for the person, and you do make a difference even of it’s just for the last day of their
To this Novice RN, serving patients and their families as they pass impacts her to want to do better to provide compassionate end of life care. Even if it is for a short time, the time she has with them is meaningful. Nonetheless, she adds that RNs become overworked dealing with short staffing, time restraints, and heavy workloads and it is difficult to provide this high level of care in these circumstances.

Nurses just become really overworked. They are maybe dealing with short-staff issues, bad issues with management, they get really burnt out, and that affects their work ultimately. It suffers, and people are overworked and just try to get their job done quickly. (Nurse 4, 1707-10)

Organizational constraints can be a source of moral distress for RNs attempting to provide high levels of care in end of life situations. The quality of care potentially suffers and impacts patients and families because RNs are overworked attempting to meet the care demands quickly. When patients and their families are not provided the care they need, it can lead to more suffering.

Another potential source for moral distress is the way do not resuscitate (DNR) orders are structured within the system and the added family dynamic when providing end of life care to patients; “I didn’t think it would be so hard to deal with the family aspect…” (Nurse 5, 2324). The DNR represents a structural factor that can create moral dilemmas. For instance, each DNR must be resigned upon readmission to hospital and the family must sign the DNR as well.

For someone to be deemed DNR, their family needs to sign, and sometimes the family’s not in agreement… I don’t agree with that all the time… We had this one patient that came in, and he coded, and he had a DNR in the community, but we legally had to do compressions on him… that’s not right. (Nurse 4, 1720-33)
The patient had a DNR but because the hospital did not have the document finalized within their facility, the RNs were legally required to do compressions. This is difficult for RNs to experience because they see the pain and the suffering this patient will endure through recovery.

Issues also come up when the family does not agree on what the patient wants. For RNs it can be difficult to communicate with the family because they do not always understand the severity of the patient’s condition;

You [RN] know the tests that they want are gonna be futile and there’s nothing you can do but you still try to accommodate because it’s a family member. . .it’s frustrating and you feel bad for the patient because they’re going through all these unnecessary tests that are causing them pain but the family doesn’t want to say good-bye so they’re trying to do everything they can. (Nurse 10, 4652-60)

It can be difficult for Novice RNs to communicate with patients’ families and this may be a source of moral distress. There is a discrepancy in how patient personhood is perceived. RNs see the patient for who they are now and the family sees the patient as who they used to be and expect them to recover.

Families are hard because they’re not in the profession and they don’t see what’s going on. . .You try to understand where they are and try to give them the information, but they’re not there yet. They see the patient as their family member. We do too, to a point but they see them how they used to be so they’re expecting that family member getting better and we can see that it’s not gonna happen. (Nurse 10, 4626-36)

Novice RNs are aware that the patient will pass and they strive to educate the family to move them through this difficult experience. RNs explain that even if you know further tests will be futile, you should try to accommodate the family. However, it is difficult for RNs to do this because they are close to the patient and know unnecessary tests are causing them pain. Novice RNs explain that sometimes they feel distressed in not knowing who to answer to; the patient or their family. In reality, RNs should answer to both.
One of the hardest parts of nursing is dealing with the patients’ families because they have expectations of how they want their family to be cared for. So, it’s hard. If they’re [patient] passing away and they want all this aggressive treatment, you have to explain that it’s probably not gonna help. You want to please the family too, but they’re not actually the patient, but they kinda are. It’s hard.
(Nurse 5, 1940-49)

When the patient passes, she says it is difficult to comfort the family, and that she still cries when that happens; “I still struggle when people pass away. It’s hard to comfort the family. I find that I still tear up when that happens” (Nurse 5, 1913-14). However, the Expert RNs explained it never gets easier, they still cry when these types of situations happen. RNs explained that they do their best to comfort the family in end of life care situations; “I always explain to the family what to expect and the medication that we can use for the patient who is dying, not just to comfort the patient but the family as well” (Nurse 6, 2510-13). They try to explain to the family what to expect and provide compassionate end of life care to comfort the palliative patient and their family.

RNs sometimes struggle to have their ethical voices heard in end of life care scenarios. Conflict can arise in their relationships with physicians when there is not an agreement on comfort measures. This is a source of moral distress for RNs. Nurse 17 explained the distress she experiences when she feels more could be done for a patient and their families as the patient passes away.

The palliative care of our hospital has come a long way, but it could be so much better. Most of the doctors are very involved. . . and there’s some on the other spectrum of things that are just like ‘it’s gonna take its course’. So, there’s difficulties there . . . we could keep them a lot more comfortable. So that’s a struggle because you’re pretty much watching them pass away. And you’re there at a very desperate time so that’s one of the constraints, being able to offer them space and being able to offer the family as much as we possibly can and we try to. (Nurse 17, 9438-50)
She describes feelings of helplessness and powerlessness when watching patients pass away. She wishes they could make patients and families more comfortable as this is a very desperate time for them. This is an example how the relationship with physicians can impact the moral agency of RNs in end of life care situations. Nurses act as a bridge between the patient, family, and other health professionals. They can experience moral distress as they are still learning how to comfort families while remaining true to their professional and personal selves.

4.4.2 Moral Agency and Moral Distress in End of life Care: Expert RNs.

To understand the significance of the RNs’ experiences with end of life care and the dynamic relationships they develop with patients’ families, it is important to look at what they have said in its context. Therefore, this section is centered on key exemplars. End of life care is difficult for every nurse who encounters it as it has the potential to lead to moral distress and moral trauma. It is, in end of life care scenarios that every topic discussed in this thesis come together; the context of the organizational culture, moral distress, and the moral agency of Expert and Novice RNs. It is in end of life care scenarios that Expert RNs integrate the various ways of knowing and showcase these abilities aesthetically. The participants explained that in the current system, RNs do not have a clear position in moral conversations, they often get caught as the bridge between patients, families and physicians. For the Expert RN, it is important to focus on the family and provide emotional support whereas Novice RNs are still learning to do this. There are different factors that explain why end of life care is so difficult and can create moral distress among RNs. Patients being admitted do not have clear advance directives, there
are complicated family relationships, and no one knows what the patient’s wishes would have been or the family revokes the existing DNR order.

End of life care is really difficult. . .people don't have clear advance directives, so they come in, they’re put on life support. Families don't know what to do, what would their loved one have wanted, or their loved one did want to be DNR, but the family revokes that. Sometimes it's just complicated relationships. So, there's always the contention, do we or don't we. The nurses do get caught in the middle of that. . .My job when a patient is dying is not to just look after the patient, but it is to look after that family. I mean so much of their grieving is going to be based on those last few hours, those last few days. So, it's so important that they get the support they need. (Nurse 20, 10820-81)

Expert RNs explained the importance of providing emotional support to the family because their grieving will be based on their last few hours with the patient. End of life care is difficult as patients do not have clear advance directives, the families do not know what to do or they revoke existing DNR. The RN can be caught in the middle of this and it can be difficult for them to have their voices heard. It can create moral distress for RNs to see patients receiving futile care and to see patients’ wishes being ignored. In our current system, there appears to be a lack of moral community between levels of healthcare making it difficult for RNs to be apart of the moral discourse and to have their voices heard. RNs expressed that their current voices are not always heard between the patient, family and physician. Further, Nurse 11 explains as an RN you become the *bricoleur* between the family and physician; “you become this strange intermediary because the doctors just don't have time” (Nurse 11, 5479). She describes this role as strange because you become an intermediary without a clear role in the moral conversation regarding the patient. An Expert RN further explains that interacting with patients’ families can be a challenging in end of life care as;
You are an outsider, you are not part of their family circle and for a very short period of time, you are allowed in... The hard part is not taking it personally when they are frustrated and not getting the answers they want. (Nurse 18, 9739-43)

RNs should remember that and not take it personally when families are frustrated, but that is a difficult part of nursing. Nurse 8 expands on this saying some families enable them to do the best they can, because they trust and support them, while others appear difficult to work with.

There are some families who just enable us to do the best we can do. They trust us, they cheer us on, they support us. Then there’s others who are very resistant, they are very resistive to the point of abusive…Some families, they just don’t know and understand so out of their unintentional ignorance, they’re barriers to us providing care. (Nurse 8, 3589-95)

In this statement the nurse has positioned the family as a barrier to care. In reality, it is more likely the responsibility of the nurse to take care of both the patient and the family. Perhaps because of the work context RNs are attempting to be efficient in taking care of the patient and as a result the family appears as a barrier. However, families have the right to ask questions and be advocates for the patient. Families journey at their own pace and part of being a moral agent is accepting the role of family in nursing care.

There are times where Nurse 20 felt that she should have advocated to families regarding patients’ DNR.

I think what bugs me the most, it hasn't set well with me, is when we've had clients who had very straightforward DNRs, advanced directives they did not want and we were prolonging their life and their suffering as per the family’s requests. And usually like I said it was those complicated, complicated relationships. Lots of guilt, lots of animosity, lots of unfinished business. I would go home at the end of the night and just think why didn't I stand up to that family and say; listen you know you are going against your loved one's wishes, it's very clear it's marked here and you are just prolonging their suffering. (Nurse 20, 11158-61)

The nurse’s stance in this statement appears to be adversarial when in reality, nurses often serve as advocates for their patients. This participant statement makes me wonder, what
the outcome would have been if her stance had been one of advocacy rather than adversarial as is suggested. After seeing the patient’s suffering appearing to be prolonged Nurse 20 questions herself as to why she remained silent. In this instance, having moral agency means she understands something morally wrong occurred, this leads her to feeling morally distressed by her inaction. However, through this experience she can grow and become a moral agent willing serve as an advocate for the patient. In the future, knowing how to exercise moral agency may prevent her from experiencing moral distress.

In the following exemplar Nurse 14 offers a historical perspective on the moral conversations of RNs in the healthcare system. She explains that nowadays moral dilemmas are more complex and you may be directed to do something by a physician or the administration, but ultimately it is the patient and their family who are the final decision makers. As an RN you need to be open and through moral agency you can determine whether or not you are the best person to help.

Everything back then, right was right and wrong was wrong, and now it can be any kind of shade in the middle. And the other thing is that a doctor may direct you do something or the government may tell you should do this or that, but in reality, the patient and their closest family members end up being the final ones who make the decision. You need to be able to know what they believe and being able to get to the point where you can either help them saying; I can take care of this person because I understand where you're coming from. Or say I may not be the best nurse for you, but I can switch and take care of somebody else's patient. . . (Nurse 14, 7892-03)

It is important for RNs to advocate for the values of nursing care in a respectful way as it allows them to be authentic in their work. It is also important for families to have the space and time to make difficult end of life care decisions and be respected in their choices. As an Expert RN with more than 35 years of experience, Nurse 18 offers a historical perspective on end of life care in the healthcare system.
Our society in healthcare is still on the notion ‘do all you can, no matter what the cost’ but it’s getting better. When I first started, physicians were really good at making those decisions. When I first started in critical care, the medical specialist would say to the family we’ve done all we can… and physicians now are coming out and saying ‘what would you like us to do?’… So, the whole way of approaching it has changed and doing it as many years as I have been doing it, I really like the whole formal way because there are lots of families who don’t want to make that decision of taking off life-support because they feel they’ve killed their loved one. There was a lot more faith in healthcare, if healthcare just said ‘there’s nothing more we can do, let’s try to make them comfortable or something’, and so we seem to have a lot less of that type of ethical dilemma. But there’s more discussion about it, there’s more research studies about it, there’s more opportunities for really looking at quality healthcare versus doing everything at any cost. Doing everything you could instead of everything you should. (Nurse 18, 10084-03)

Here the Expert RN provides us a historical look at acute care over the years that she has worked. Traditionally, there was more faith in the healthcare system and physicians decided when to take someone off life support. Nowadays, families are asked what they would like to do, the Expert RN explains that it is difficult for families to have that responsibility. She explains how the structure of end of life care functions and how currently there is more discussion on quality healthcare instead of doing everything at any cost. There is a difference between doing everything “we can” instead of everything “we should”, the end result being a comfortable death versus a difficult death. In the following exemplar, Nurse 8 explains the difficulty in meeting both the needs of the patient and the family during end of life care.

A moral dilemma for us would be understanding what a resident wants for end of life care and their families not being in agreement with that and it has given us challenges because ethically, who are we supposed to respond to? A resident saying ‘I just want to die’ and the family saying ‘do everything you can to save them’ and we’re administering medication and doing procedures, and we’re not sure who we’re supposed to answer to. So that’s one. Because we get to know the residents, to know them as people, we feel very accountable to the residents but we also feel accountable to the families. (Nurse 8, 3601-10)

Here Nurse 8 explains a moral dilemma and the distress felt when families are not in agreement with what the patient wants for end of life care. When there is discord or
disagreements the challenges and risk for moral distress increases exponentially, but such is the reality of nursing. RNs feel responsible for patients because they have a bond with them and they see their personhood, but they also feel accountable to the families. In the end, these situations create moral distress in that RNs are simultaneously accountable to both the patient and the family. Having a binary perspective between the patient and the family may lead to increased moral distress. There are tensions in the death and dying process, end of life care situations are beyond binary, it is complex, and each family must be allowed to journey at their own pace.

Other nurses share similar stories. The following exemplar by Nurse 14 explains the difficulty in helping both the patient and the family in end of life care. She explains that their most common moral dilemma pertains to the process of death or dying in helping families understand when to “let go”. It is important to note that having moral agency does not mean telling a family they need to “let go”. Contrarily, it means being an advocate not an adversary to the family. Families in these situations are under stress, they need space and time when making end of life care decisions. Nurse 14 with 36 years of experience has integrated into practice the fundamental ways of knowing and can tell when a patient who can no longer talk tries to voice they have had enough. However, it is important to not that as moral agents it is not RNs roles to judge when the family should “let go”. There is a fine line between advocacy and having an adversarial stance against the families’ wishes for the patient.

How to help families know that point when a person's physical body has taken all the antibiotics, and all of the treatments and all of the everything that they can and that body isn't going to be able to keep going. Or that you can see that loved one at the point where, even with elderly people who can't talk, you can tell when they're saying 'I've had enough'. And you have to explain to families 'this is when your
loved ones has had enough, and you need to be ready to let them go’ because not everybody’s at the same stage within a family, to be able to let that person go. And helping families understand the decision of what an advanced care directive is and when CPR is good and when CPR isn't gonna help… I can remember one women who, I knew her as a person, and she had ended up coming into our intensive care unit, and we broke her ribs, and when she'd see me after that around town, she'd tell me 'oh, don't ever let them do that again'. It took her months for her ribs not to be sore. But yet, when family members come in, they don't understand what CPR's gonna do and the effect it's gonna have. And sometimes it does awesome, and it changes a person's life so that they live and do great and other times it doesn't. So, getting through that process is difficult. (Nurse 14, 7615-41)

While it is important that families understand the impact of CPR and aggressive treatments on dying patients, RNs should respect the families’ wishes even if they disagree with them.

This can be difficult to do and can create distress for the RNs who see aggressive treatments as futile care. However, Nurse 14 also explains going through this process with a family member, it was extremely difficult and helped her understand what her patient’s families go through.

For me, the hardest was not dealing with the families who were my patients', my residents' families; it was when I had to speak to my own children about their father. And tell them 'this is what palliative care is, this is what terminal care means, this is what an advanced directive is, and we're gonna sit down and talk about these things'. And that was probably my hardest thing because it took me from doing this as a nurse to doing this as a wife and as a mother. And my most difficult part was, I knew the death and dying process really well. I had taken care of people in that zone for many years. Most of my 36 years. But I had no clue what the process would be after that person passed away, and even though I understood, I had no clue what those family members went through after they took the belongings out. I had no clue and how long it would take. Oh, my goodness, so much longer than I thought it would take and so much more difficult. (Nurse 14, 7642-57)

Understanding the death and dying process from a family perspective was extremely difficult for Nurse 14, but ultimately it helped her in her work. She now has a different view of the death and dying process even though she understood this process professionally. Experiencing this as a wife and mother was life changing, as it allowed her to become morally authentic in her work. She has a powerful understanding of what
families go through and this allows her to provide empathetic and compassionate care to patients and families.

Nurse 18 also shared a similar experience. In the exemplar below, she shares a personal story of experiencing the death and dying process from a family perspective and how it helps her in her practice and in teaching other nurses.

Years ago, my dad had (name of condition), and I knew he was going to die. The physician approached us, we had already said from the beginning, he did not want heroics, he was gonna be a do not resuscitate. We were in the 4 patients per room and we’re a family of many kids, with spouses and grandkids all very close to grandpa. They offered us a private room. But then that would mean disconnecting dad from all the intravenous and everything. I knew that was the way to go. I knew how nice it would be for all of us to be sitting in one big room with dad in the centre. My mom always looks to me for healthcare stuff and she said ‘dad’s gonna die, isn’t he?’ and I said yeah, and so I gave her this explanation of what we could do and she said ‘but we’d have to take dad off of IV drips’ I said ‘Yeah’ ‘I can’t do it, I can’t do it’ and even though I knew it could be better, mom had to live with the decision she made. I tell this story to nurses’ time and time again, even though we know what the end’s gonna look like and we know how beautiful it could be, their immediate family has to live with themselves after. So, in those types of ethical decisions, patient A may be in a vegetative state, what we’re providing care now is the family. We’re providing physical care, we can’t do anything more. We are helping the other members to survive, and some members can come to a decision within 5 to 10 days that they need to take them off life-support. Other families will take 2 years. Everybody’s different and our job is to help support them so they can look at themselves in the mirror at the end of the day. It’s not up to us to judge like the fact that they haven’t seen their family member in 5 years and now they feel guilty. We have to do our very best work in 12 hours and then go home to our own families. (Nurse 18, 10109-39)

In this exemplar, Nurse 18 explains how difficult it was for her family go through the death and dying process. Although she knew as an RN what the end could look like, she had to accept that her family saw it differently. Although the family knew their loved one was going to pass, they found themselves unable to let go. Nurse 18 explains that as an RN even if she knew it could be better, it is her family that would have to live with the decision. She tells this story to other RNs to teach them they cannot judge families who make these
difficult decisions because it is the immediate family that has to live with themselves after
the patient has passed. In these instances, your role as an RN is to provide physical care to
the patient and support the family emotionally and respect their decision. This means there
is a difference between having one’s ethical voice heard and imposing one’s beliefs and
values on others. It is the family who needs to look at themselves at the end of the day and
feel at peace with their decision rather than feel as if they have called death to their loved
one. Nurse 18 explains that some families will come to a decision quickly while for others,
it may take years because of complicated relationships. In the end, RNs role is to do their
best and at the end of the day go home to their own families. She later explains that “the
toughest times, isn’t always dealing with the patients and the family, it’s helping the nurses
through something” (Nurse 18, 10060-62). She sees RNs connecting with patients and
becoming morally distressed. As an Expert RN she sees beyond this and notices that the
hardest is supporting other RNs in dealing with the death and dying process. She states
that for nurses;

   The most difficult time is when they’re providing care they don’t think is needed
   but I think what you need is strong people to support and counsel the entire staff
   about; it’s not our decision even though we feel like it is. (Nurse 18, 10069-72).

RNs feel responsible towards their patients and providing futile care can lead to moral
distress. Nurse 18 explains that it is important to support the other RNs to alleviate this
distress. It is not up to the RNs to judge quality of life of patients in life and death
situations, these are decisions made by the families.

   Expert RNs explained that there are issues in how DNRs are perceived in
healthcare. The participants explained that DNR does not means do not give care. It is still
important to provide compassionate palliative care.
DNR doesn’t mean do not provide care, it means do not resuscitate at the end of life. So once the heart stops, I will not do CPR, if they stop breathing, I will not put them on artificial breathing machines. Otherwise, we will provide the best care we can. There’s a difference between DNR and compassionate terminal care. So compassionate terminal care, yes, we will do everything to keep them comfortable and stop absolutely everything, so there’s a difference legally but there’s also a difference to us. So, I just wanted to stop that whole idea now that just because a patient is DNR that we do not provide care…We provide everything. (Nurse 18, 10153-63)

DNR does not mean no treatment, to me, you still need comfort measures… I'm kind of in the middle gray zone, maybe not the antibiotics, but come on why not a little bit of IV fluids, some IV morphine, let's keep them comfortable… Not to give them (family) false hope, but just that they made this decision that oh my gosh I think I've called the death sentence. (Nurse 20, 10844-67)

End of life care is a complex issue, which can lead to moral distress among RNs. It is important for RNs to have a deep understanding of what end of life care and DNRs mean. It is important for RNs to focus on the patient’s family and provide emotional support, but most importantly it is crucial that nurses support each other in their work.

In end of life care, Novice RNs appeared to focus on the patient and working with the family was stressful so much that it caused distress, whereas the Expert RNs explain that they attend to the needs of the patient but also provide emotional support to the family. By focusing on the family, Expert RN alleviate the distress and find meaning in providing emotional care to the family as the patient is nearing death.
4.5 Conclusion of Findings

Through the voices of RNs, it is evident there are organizational factors leading to moral distress and impacting moral agency such as time, workload and staffing. Through the model one can see that these constraints spiral down to create a negative organizational context impacting the RNs perceptions of the administration. Novice RNs experience heavy pressures and can become overwhelmed which impacts their moral agency and may lead to moral distress. Expert RNs face the same organizational constraints but have adapted to survive in the system. They learned to use their moral agency but they are not immune to moral distress and can still encounter situations where their voices are unheard because of the structure of the system. End of life care situations demonstrate how the context of the organizational culture, moral distress, and the moral agency of RNs interact and impacts RNs, patients and families.
CHAPTER FIVE: Discussion

In this chapter, I discuss the implications of the findings at theoretical and practical levels. Through their work, nurses strive to maintain their integrity, and the values emphasized in the CNA Code of Ethics. It is important to explore what occurs when nurses are constrained in converting moral choices into moral action (Rodney et al., 2013). The purpose of this study was to explore moral agency and moral distress among Novice and Expert RNs as well as determine what bureaucratic factors impede moral agency and lead to moral distress. Raines’ (1994) definition of moral agency was used when discussing the voices of RNs in the healthcare system. A moral agent understands the responsibility in their freedom, has the ability to recognize issues, and has a willingness to act (Raines, 1994). Moral agency provides insight into “how nurses choose to act when faced with a choice among conflicting values and principles” (Raines, 1994, p.5). Milliken (2018) goes further by conceptualizing moral agency as the ability and willingness to act on behalf of patients.

In current nursing literature, moral agency is framed in relation to moral distress which is the feeling (real or perceived) that one cannot do what they feel is right because of system structures or internal factors (Jameton, 1984; Rodney, 2017). There are consequences to moral distress such as frustration, and guilt. However, moral distress can also be used for self-reflection, growth and advocacy (Rodney, 2017). According to Austin (2016), nurses can experience moral distress because of a sense of powerlessness in attempting to be moral agents. The dynamic between moral agency and moral distress in healthcare is impacted by context (Milliken, 2018). Organizational culture and bureaucratic factors within the system play a part in the success or inability of nurses to
exercise moral agency. Moral distress among nurses is a sign of systemic failures to facilitate ethical nursing practice and potentially placing patient safety at risk (Milliken, 2018).

5.1 Organizational culture in healthcare

The findings demonstrate that organizational factors such as understaffing, heavy workloads and time constraints appear to impede moral agency and lead to moral distress among nurses. The current organizational context of healthcare appears to warrant Novice RNs performing at a high level quickly into their careers. Organizational context has a profound impact on nurses’ ability to take moral action (Milliken, 2018). Novice RNs face challenging ethical situations early in their careers and may become overwhelmed by the workload. Novice RNs need to be moral thinkers from the beginning of their careers and have the ability for quick decision making in complex situations. As stated by Expert RNs, Novices can also ask for help when they do not know the right action to take. As seen in theme one, both Novice and Expert RNs appeared morally distressed when describing their attempts to provide high quality care under time constraints. It appears difficult to develop therapeutic relationships with patients in this organizational context and this contradicts the traditional values of nursing (Raines 1994). For example, in the context of end of life care situations, nurses reported a lack time to provide care to the family while also juggling making the bridge between the patient, family and physician. It is important to highlight the role context plays in nurses’ moral judgements and decision making (Paley, 2012).

A focus on productivity, efficiency and effectiveness in healthcare appears to move the system away from patient-centered care (Peter & Liaschenko, 2013; 2016). Nurses experience moral distress when striving to balance efficiency in providing care and taking
the time to care compassionately. As seen in the findings, Novices and Experts questioned whether they provide care or are task-oriented. In this case nurses should enact moral agency in a moral context where their own values compete with those of the organization (Varcoe et al., 2004). Being moral agents ensures actions are based on patients’ needs rather than taken based on the organizational context (Milliken, 2018). This perspective enables moral agency to be enacted in a context supporting nurses’ ethical voices (Milliken, 2018).

Past research has linked moral distress to excessive workloads and difficulties with end-of life decision making (Musto, Rodney, & Vanderheide, 2015; Rodney, 2013). Quality of care is negatively impacted when nurses face shortages in time and staff (Austin, 2003). As explained in theme one, Novice and Expert RNs struggle when working short. They work even when they are sick because they do not want to leave their team understaffed. This demonstrates a systemic error nurses should not feel guilty for calling in sick, nor should they sacrifice their health to keep the system going. Additionally, these practices may place patient safety at risk and appear to lead to moral distress among nurses. Literature supports that moral distress has been linked to staff turnover, decreases in quality of care and decrease in patient safety (Burston, 2013; Rodney et al., 2013). Studies have shown that turnover rates for new nurses is 30 to 60% within the first two years of their careers (Beecroft, Dorey, & Wenten, 2008; Bowles & Candela, 2005). This is a great loss for the healthcare system that has invested resources in recruiting and training. Novice nurses enter the profession expecting an organizational environment that will support them in their efforts to provide high-quality care consistent with the fundamental values of nursing (Laschinger, 2012). Expert RNs also expect to work in a context that offers respect
and acknowledgement of their rich experiences and commitment to nursing (Price & Reichert, 2017). Expert RNs represent a significant portion of nurses in the workforce (Price & Reichert, 2017). Although they are moving towards retirement, Expert RNs are willing to stay in the nursing profession if their work context is positive and supportive (Armstrong-Stassen, Cameron, Rajacich, & Freeman, 2014). Nonetheless, moral distress is predicted to continue to rise because of the complexity of the healthcare system (Rushton, 2016). As demonstrated in the findings, nurses working within a constrained context can be prevented from exercising moral agency because of; time constraints, heavy workloads and understaffing.

5.1.1 Perceptions of administration.

In the findings, RNs explained their perspectives of the administration in healthcare. Further research would be required to more fully understand at what level in administrative domain the nurses’ concerns are directed. Nonetheless, it is important to explore the reciprocity between organizations and individuals in acknowledging that they impact each other (Rodney, 2017). By doing this, moral distress can be understood through a relational ethical perspective (Rodney, 2017). Nurses, patients, families, and administrators interact, and act in relation to each other in a complex organizational culture (Rodney, 2017). The connection between individuals and structures can help policy makers and administrators in developing a relationship with nurses and find effective interventions and increase moral agency and prevent moral distress. Therefore, the organizational factors presented in the findings should be addressed at all levels, from the nurse to the larger system and its structures.
At the political level of healthcare, leaders need a better understanding of the challenges facing frontline nursing (Rodney, 2017). As suggested by participants, administrators may visit both acute and long-term healthcare establishments to experience the everyday realities of nurses. There is a need to develop fair processes that includes the voices of Novice and Expert nurses in decision-making at a larger level (Rodney, 2017).

It is important to cultivate a culture where ethical values drive practice at all levels of healthcare. With increased support, opportunities for additional education in ethical care, and meaningful collaboration within the ranks of healthcare, a moral community can be fostered where safe, competent and ethical care is promoted (Rodney, 2006). Creating a moral community emphasizes the team aspect of moral agency in a bureaucratic system.

The CNA’s definition of a moral community is

A workplace where values are made clear and shared where these values direct ethical action and where individuals feel safe to be heard. Coherence between publicly professed values and the lived reality is necessary for there to be a genuine moral community. (p.24)

Through the three themes discussed in the findings of this study, it is clear that a moral community is lacking in the healthcare system as the values publicly professed (i.e. patient-centered care) do not always align with the realities encountered by nurses. The CNA Code of Ethics in its 2017 edition emphasizes the importance of creating moral communities within nursing; however, it is my belief that to be successful, moral communities must include all levels of the healthcare system, by giving a moral voice to all its members. The CNA states

Nurses work collaboratively to develop a moral community. As part of this community, all nurses acknowledge their responsibility to contribute to positive and healthy practice environments. Nurses support a climate of trust that sponsors openness, encourages the act of questioning the status quo and supports those who speak out in good faith to address concerns. (p.16)
While it is true that nurses are responsible for contributing to a positive organizational culture, it is impossible to expect nurses to create a moral community on their own. It is the responsibility of all healthcare professionals, and administrators to construct a moral community within healthcare. Putting the responsibility on the nursing body will not foster a moral community in healthcare. Contrarily, it would continue to perpetuate the perceived negative perceptions between nurses and the administration.

5.2 Moral Agency and CNA’s Code of Ethics

In 2017, the CNA, updated their Code of Ethics, revising their definition of moral agency to; “Someone who has the capacity to direct their actions to some ethical end, for example, good outcomes for patients” (p.6). However, as stated in the literature review (2.2.3) their definition of moral agency still lacks clarity and does not encompass the seriousness of its importance. The only difference between their 2008 and 2017 versions are that they have changed the ending to involve patients. The findings of this study, specifically Theme Two, which discusses the development of moral agency from Novice to Expert, suggest that the definition of moral agency by the CNA does not reflect the complex realities faced by nurses in healthcare. For example, the CNA Code of Ethics simplifies the concept of moral agency by using the words ethics and moral interchangeably. They acknowledge that not every scholar agrees with this use of the words. However, it is my belief that philosophy distinguishes an important difference between morals and ethics. It is specifically important to distinguish between the two terms when discussing moral agency since it impacts its definition. Moral agency is centered on the values of the individual in guiding decisions, while ethics is context driven. An ethical decision focuses on the environment in which the dilemma occurs. It does not necessarily
consider the individual’s values in the dilemma. However, morals are centered on one’s core values and principles which impacts decision-making.

As explained in the literature review (2.2.3) this definition still does not align with existential thought in which moral agency is rooted because it does not mention acting in good faith. The importance of having an inclusive definition is illustrated when looking at the ethical and moral issues nurses encounter in end of life care situations (Theme three). For example, the CNA’s new definition states being a moral agent means acting ethically towards the good outcomes of patients. However, how does a nurse be a moral agent if a patient signed a DNR and the family revokes it? Or how does the nurse be a moral agent when providing futile care? To find solutions, it is necessary for processes to be created allowing Novice and Expert nurses to have their voices heard with the intent to action.

5.3 From Novice to Expert to Now

In 1984, Benner, wrote a classic, From Novice to Expert, where she examined the journeys of nurses throughout their careers. She evaluated the levels of proficiency of 67 nurses, working in different settings. Even then she noticed an increase in the acuity of patients, decrease in lengths of hospital stays and a need for experienced nurses in the system. The findings of this thesis suggest that the healthcare system has continued unto this path. Jameton (2017) suggests that “if moral distress is increasing and spreading among health professionals, one simple explanation may be that many hospitals provide care at higher levels of acuity than in the 1980s” (p.620). The complexity of care and increase in responsibilities requires nurses to be morally aware from the start of their careers. In the current healthcare culture, there are high expectations, and demands on
Novice RNs, this environment can put them at risk to moral distress. Based on the findings, there is also an expectation for rapid growth, it appears Novice RNs need to move into sophisticated practice at a faster rate now than ever before.

Benner would suggest that the parameters for Novice RNs are between 0 to 5 years of experience while an Expert would have 5 years and counting. Nonetheless, as stated by Benner (1982) “…experience is not the mere passage of time or longevity…” (p. 407). Experience is a combination of time and quality of the experiences through the context nurses work in. As seen through the findings, the current practice context in acute care and in long term care is demanding physically, mentally, emotionally, and morally.

Novice RNs have limited understanding of the contextual meaning of the environment they work in; they are limited to the novice level of performance as the goals and tools of patient care are unfamiliar (Benner, 1984). They lack the context driven awareness and skills only gained through real-life situations (Benner 1984). Benner explains that Novice RNs require support in setting priorities. At this level their patient care must be reinforced by experienced nurses (Benner, 1984). In the findings, it was evident that Novice RNs do not always have experienced RNs by their side. They are expected to ask others if they do not know, as some interventions require two RNs. The climate that Novice RNs currently work in has made the learning curve steep. Because of the complexity of care and increased in workloads, there is an urgency for Novice RNs to become knowledgeable and skilled quickly. The Novice to Expert linear path is not so linear or traditional anymore. Ultimately, Novice RNs need to “hit the ground running” in having strong moral awareness from the start of their career.
Benner (1984) suggests that a Novice RN does not have enough experience to identify a situation in relation to its bigger picture or understand what is most important in nursing care. While Novice RNs have fewer years of experience they gain rich and intense experiences that pressure them to develop quickly. Many Novice RNs in this research appeared to begin to see the whole picture of the healthcare system. They seemed distressed because their voices were unheard and they could not act to improve patients’ circumstances beyond meeting their immediate care needs.

After gaining experience for two to three years, Benner (1984) suggests RNs begin to demonstrate competence by seeing their actions as part of a bigger picture and by following plans; “For the competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem” (p.26). At this level, Novice RNs appreciate following analytic principles such as rules and guidelines to base their practice. Benner (1984) explains that “the conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organization” (p.26). Nonetheless, the Novice nurse still lacks the speed and flexibility of the Expert nurse. Seeing one’s actions as part of a larger goal helps the RN develop the ability to prioritize. In this study, it was evident that Novice RNs are efficient, and adaptable in their work because of the organizational challenges they face in caring for patients. As Novice RNs develop proficiency they perceive situations holistically rather than as entities. This is key, as it means they perceive the meaning of situations in the long term. Nonetheless, they still act based on rules and guidelines (Benner, 1984). As seen through the findings, at this level they begin to determine when plans need to be modified for patients and recognize distress. This holistic understanding can help the Novice nurses’ decision
making. As seen in the findings, Novice RNs want to have their voices heard and do have an understanding of their role in decision-making.

At the Expert level (after approximately 5 years of experience), the RN no longer depends on rules and guidelines to link theoretical understanding to practical action. According to Benner (1984); “the expert, with an enormous background of experience, now has an intuitive grasp of each situation and zeros in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions” (p.32). Expert RNs have integrated the various ways of knowing (Carper 1978) and have a holistic understanding improving their decision making. This is true and it was seen through Nurse 8’s story in long term care regarding allowing a patient to take their medication at a later time than scheduled. While Novice RNs may rely more on rules to guide decisions, Expert RNs rely on past experiences to guide their practice; it is intuitive. This intuition is experienced-based as it is a culmination, a history of patient care situations, and an understanding of the complexity of care. Benner argues, that if Experts were asked to act based on formal rules or guidelines their performance would decline. For Expert RNs, rules are at the unconscious level, deviating from them allows for faster and better performance. As seen through Nurse 8’s story, an Expert RN deviated from abstract rules to tailor care to meet the specific needs of a patient. Having the skills of an Expert RN is extremely important when nursing in end of life care. As described by Benner (1984), Expert RNs;

who have come to grips with the culturally avoided or uncharted and can open ways of being and ways of coping for patients and the family. . . [Experts] in their practice, by the way they approach end of life care or the way they talk about recovery from an illness offer ways of understanding and avenues of acceptance. (p.407)
Expert RNs have a coaching ability, they can help patients and families cope and move them towards acceptance in difficult situations such as end of life care.

**5.4 Implications with End of life Care**

Novice and Expert nurses are exposed to the death and dying process in both acute and long-term care settings. The foundation of nursing is to care for patients even when it seems like they are not progressing towards healing (Beckstrand \& Kirchhoff, 2005). In this study, Novice and Expert nurses experienced moral distress in providing futile care. This is also supported by past research who found that moral distress is associated with medical situations representing futile care (Mobley, Rady, Verheijde, Patel, \& Larson, 2007). According to Mobley and colleagues (2007) between 66 to 89% of nurses in their study encountered futile care situations associated with moral dilemmas with patients, families, and administration. This is concerning as these situations represent an area where the moral voices of nurses remain unheard impacting their well-being. In these situations, nurses stated administering aggressive treatments, at times going against patient wishes because of family pressures. These life-prolonging interventions may go against with delivery of supportive care (Shepard, 2010). How does providing this type of care impact Novice and Expert nurses who are committed to the values of caring and compassionate nursing? The findings demonstrate that it puts nurses at risk of suffering from moral distress.

To minimize moral distress and lessen the pressure on nurses, the healthcare system would be wise to advocate for patients and families to come to agreement and complete advanced care directives (Shepard, 2010). Novice and Expert nurses explained
there are inefficiencies in the current structure of advanced care directives. While they provide a voice to patients and preserves their autonomy in a health crisis, families can override the patients’ wishes. When adhered to, advanced care directives provide nurses and physicians guidance to determine appropriate care and lessens moral distress (Shepard, 2010). Institutions have the power to increase moral agency and lessen moral distress by supporting nurses through ethically complex situations (Shepard, 2010). For example, administrators can support nurses in honouring advanced care directives regardless of pressures from families, however there are also ethical legal perspectives to consider. The power of attorney has the legal right to make decisions on behalf of the patient. There are legal perspectives to consider in end of life care situations going beyond the realms of nursing, ethics and morals. Novice nurses may require additional support and ways to discuss ethically challenging cases (Shepard, 2010). Collaboration between the nursing team and physicians is also needed to determine appropriate care in end of life scenarios. As stated by Expert nurses, compassionate end of life care should be available for patients, services can include sufficient pain medication and IV fluids.

When facing the death and dying process, Novice and Expert RNs are set apart in three ways in their actions, in their relationships with others and in their attitudes towards suffering (Frankl 1964). For example, Novice and Expert Nurses responded to the suffering they witnessed and strived to make a difference for patients. Further, Expert RNs instinctively demonstrated the ability to respond to the personhood of each patients by creating therapeutic relationships with them and their families. This can be difficult for Novice RNs to do as their actions may be limited by organizational constraints. The findings demonstrated that the structure of the healthcare system does not appear to foster
an environment encouraging nurses to create these bonds with patients and ultimately find meaning (Frankl, 1964). As demonstrated through the findings, Novice and Expert RNs work hard to offer patients compassionate care. For example, some go beyond by sacrificing personal time to stay late at work if it means reassuring a family making difficult end of life choices. Considering this, and the organizational constraints faced by nurses, it is necessary to look for solutions that will attempt to increase moral agency and decrease moral distress.

5.5 Recommendations

At the organizational level, nurses, other health professionals, and administrators can collaborate to create ethical policies and practices (Rodney, 2017). For instance, they can address the need for individualized care in acute and long-term care settings. There is a need to address the bureaucratic constraints by including organizational and policy measures to reduce the occurrence of ethical problems in acute and long-term care settings (Austin, 2012; Ruger, 2008; Ruger 2008; Kohn, Corrigan, & Donaldson, 2000). The literature also supports including various levels of healthcare professionals to improve multidisciplinary communication and create a shift in organizational culture (Levine-Ariff, & Groh, 1990; Pavlish, Brown-Saltzman, & Wong, 2016).

At the epistemological level, researchers should continue to seek a better comprehension of how to best support Novice and Expert nurses practicing within complex organizational structures and systems (Musto et al., 2015; Musto & Rodney, 2016; Rodney, 2013; Rodney et al., 2013). For example, to address the moral distress of a nurse working in a busy acute setting who wants to provide compassionate and a high level
of care but faces insufficient staffing. There is a need to better understand what kind of support would allow nurses to cultivate moral agency allowing them speak up. As stated in the literature review (2.4), researchers suggest moral distress can be decreased by encouraging nurses to be more resilient in speaking up (Rushton, Schoonover-Shoffner, & Kennedy, 2017). However, theme two demonstrates that the Novice to Expert journey to having the courage to speak up is not that simple. It takes time and even Experts have no assurances that their voices will be heard. It also appears that few participants mentioned venues where their voices could potentially be heard such as through their union and their provincial nursing association. Further research is needed to understand why these potential options for moral agency were not emphasized by the nurses.

Another recommendation mentioned in the literature is increasing nurses’ preparation to ethical issues through education (Lang, 2008). Nurses should be trained to think ethically and morally from the start of their careers. There is a need to question how applied ethics is are taught. Are students provided with an understanding of moral agency and moral distress? How can we teach about moral agency and moral distress within nursing in Canada? As educators and patients, we should all be very concerned about this.

Training should also be available throughout nurses’ careers to improve their ethical reasoning (Lang 2008). Researchers also believe that ethics education could be used to prevent and address moral distress (Corley, 2002; Ruston, 2006). Education can accomplish this by helping nurses understand ethical values, clarify personal values, and recognize resources within the system.

Nurses in this study demonstrated moral and psychological resilience in their ability to keep going when encountering difficult experiences and challenges. Moral
resilience has been defined as the ability to restore or sustain one’s integrity when facing distressing situations (Rushton et al., 2016). Psychological resilience is the ability to bounce back from stress, it encompasses the three factors of hardiness: commitment, control, and challenge (Hart, Brannan, & De Chesnay, 2014; Maddi, 2013). The findings of this study show that RNs put their physical needs aside and keep going to meet the needs of patients in a demanding organizational context. The difference in resilience between the Novice and the Experts RNs is that Experts have successfully kept going through years of practice. The quality of their experiences in healthcare’s practice context distinguishes them from Novice RNs. Resilience has been identified as an important factor for lifelong health and well-being (Haskett, Nears, Ward, & McPherson, 2006). A recent study comparing resilience among nurses in Canada and in Singapore continues to link resilience to lower levels of burnout, turnover, and traumatic stress. This study found that building resilience among nurses is one way to support RNs and allow them to flourish (Ang et al., 2018). It is important to teach RNs resilience strategies to prevent and respond to moral distress. Overall, there are many avenues to improve moral agency and address moral distress in the healthcare system. It is essential that systems and organizations such as the CNA move towards promoting the implementation of the listed recommendations.
CHAPTER SIX: Conclusion

This research aimed to explore moral agency and moral distress among Novice and Expert registered nurses as well as the impact of bureaucratic factors. More specifically, the research questions concerned identifying organizational factors impacting moral agency and leading to moral distress, as well as understand the differences and similarities between the moral agency of Novice and Expert RNs.

This research utilized a constructivist epistemology, De Groot’s methodology and thematic content analysis. Twenty registered nurses were recruited and interviewed in a Northern Urban setting. The findings demonstrate that nurses want to provide a high level of care but are often constrained by organizational factors such as understaffing, heavy workloads, and lack of time. These factors demonstrate a tension between organizational values of efficiency and effectiveness and taking the time to provide compassionate patient-centered care. Through the model constructed one can see that these constraints impact the RNs perceptions of the administration. It is clear that the increasing pressures on the healthcare system have led to an urgency for Novice RNs to quickly develop and consolidate their knowledge, skills and clinical decision-making as the learning curve is steep. However, Novice RNs can experience difficulty in having their voices heard. Expert RNs face the same organizational constraints but have survived in the system. They learned to speak up, but they are not immune to moral distress. They can still face scenarios where their voices are unheard because of the system’s structure. Nursing in end of life care reveals how the context of organizational culture, moral distress, and moral agency interacts and impacts RNs, patients and families.
Numerous recommendations can be implemented to work towards increasing moral agency and decreasing moral distress. Examples are the promotion of moral communities in the system, interdisciplinary discussion among health professionals to change the organizational culture, policy changes, and most importantly discussing how applied ethics are taught to both Novice and Expert RNs. Implementing these recommendations and talking openly about moral agency and moral distress gives nurses the chance to overcome trauma and work in a more supporting system. Further research can determine how these avenues would benefit the system economically as it would surely lead to a decrease in burnout, absenteeism, and turnover. One thing is certain, nurses are the largest body of health professionals in Canada and worldwide, we, as researchers, educators, health professionals, patients, and the public should work towards creating a system empowering nurses to be moral agents. Why? Because our care depends on it.
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## Appendix A: Participants’ Characteristics

*Participants’ Characteristics*

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<th>Expertise</th>
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Total: 11 Novices 256

9 Experts Avg. 12.8
Appendix B: Initial Letter of Contact

June 27th 2017

ATTN: Letter of Initial Contact

Dear Potential Participant,

My name is Elisabeth Fortier; I am a Master student in Kinesiology & Health Studies at the University of Regina, SK. I am conducting my Thesis research with nurses and would appreciate your participation! The title of my research is Moral Agency among Nurses: Northern Urban Healthcare Culture. I am exploring the voice of nurses in a northern urban healthcare setting. This research will give nurses the opportunity to reflect on and discuss their voice in the healthcare system and the meaning they find in their work. Moral agency is our ability to be authentic by using core values to guide decisions; it is our voice. Advancing knowledge on moral agency is needed to strengthen the voice of nurses in the Canadian health care system. This research is a necessary step towards creating more positive work environments in healthcare, increasing the wellbeing of nurses and improving patients’ quality of care.

In the Summer 2017, I plan to interview 20 nurses (for 30-45 minutes) in a location that is convenient to you (i.e. your home, or a rented private space). Participants will receive a $10 Tim Hortons gift card as a thank you for participating. If you choose to participate, your identity will be kept confidential. Eligible participants are males or females, of any age or cultural/ethnic background, currently (or recently retired) registered nurses, nurse practitioners, or licensed practical nurses. Nurses need a minimum of one year experience in nursing.

There are minimal risks associated with this research which are managed and further explained in the consent & confidentiality form. In short, a confidentiality agreement between you and the researcher protects your identity as participant. Your employer/union/governing body will not be made aware that you are participating. By sharing de-identified information you also adhere to the regulations of the health information act and respect your ethical responsibilities regarding privacy. To further protect your identity please use your personal email rather than your work email to communicate regarding the research. To avoid emotional discomfort, each question in the interview has been made optional. This research has received approval from the University of Regina Research Ethics Board. I am available any date after July 13th to meet with you, your collaboration would be greatly appreciated!
Appendix C: Consent & Confidentiality Form

Faculty of Kinesiology and Health Studies
Centre for Kinesiology, Health & Sport

Participant Consent Form

Project Title: Moral Agency among Nurses: Northern Urban Healthcare Culture

Researcher: Elisabeth Fortier, Student, Master of Science in Kinesiology & Health Studies, University of Regina, (306) 314-5513 forteiel@uregina.ca

Thesis Supervisor: Dr. David Malloy, Professor, University of Regina, (306) 585-5184, david.malloy@uregina.ca

Purpose(s) and Objective(s) of the Research:
- The purpose of this research is to explore moral agency among nurses in a Northern urban healthcare setting. The objective is to explore and understand the ethical voice of nurses and their perceptions on the patient experience in this healthcare setting. Advancing knowledge on moral agency is needed to strengthen the voice of nurses in the Canadian health care system.
- This research is a necessary step towards creating more positive work environments in healthcare, increasing the wellbeing of nurses and improving patients’ quality of care.

Procedures:
- Data will be collected in summer 2017, interviews will last between 45 mins to an hour, they will be audio recorded, and conducted by researcher Elisabeth Fortier. Location for the interviews will be at your convenience (i.e. in your home, or rented room at a library).
- After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts.
- Participation is voluntary; participants will receive a 10$ gift card as an incentive to participating.
- Questions are welcomed regarding the procedures and goals of the study or your role as participant.

Potential Benefits:
- By participating in this research, you have the opportunity to reflect on the impact of your voice in the healthcare system as well as share experiences and thoughts on working as a nurse in your community. This process can be valuable in your journey to finding meaning in your profession and reaching authenticity.

Potential Minimal Risks:
- There is a minimal risk of being identified as participant.
  - There is a limit to confidentiality due to context!
    Participants for this research have been selected from a small group of people, all of whom may be known to each other, because of this, it is possible that you may be identifiable to other people on the basis of what you have said.
  - You may be referred to the study by a person outside of the research team (this is called snow ball sampling). However, to protect your identity this individual will not be made aware whether or not you have been chosen for the study.
  - To avoid problems where you may know who was involved in a particular situation, the researcher asks you to use de-identified information in describing your experiences. Rather than focusing on providing specific details of a situation, the researcher asks that you reflect on your personal role, how you felt and how it has impacted you.
- Minimal risk for legal repercussions for participating in the study.
This risk is managed by adhering to the Saskatchewan Health Information Protection Act. According to this Act you can disclose health information if it is considered de-identified personal health information which is health information that does not identify the subject i.e. the patient. To protect you and the integrity of this research you cannot disclose any information that could reasonably identify the subjects i.e. patients or people involved. In sharing de-identified information you adhere to the regulations of the health information acts and also respect your ethical responsibilities regarding privacy.

- There is a minimal risk for social repercussions. The nature of the questions may result in you making critical statements of your employer and others working in the health district.
  - To manage this risk, this confidentiality form between you and the researcher protects your identity as participant. Your employer/union/governing body will not be aware that you are participating, and if you recommend other potential participants you will not be made aware of who is selected. Further you are advised to use your personal email rather than your work email to communicate regarding the study.

- Potential minimal risk for psychological or emotional discomfort in answering interview questions.
  - To manage this, you will be informed before the beginning of the interview that each question is optional and you can choose to not answer any question for any reason during the interview.

Confidentiality:
- The data collected is intended to be used for a Master of Science Thesis in Kinesiology and Health Studies. Findings may be published as a journal article, poster or presented at conferences; however, your identity will be kept confidential. Although we will report direct quotations from the interview, you will be given a pseudonym, and all identifying information (details on your position, where you work, your age, where you are from, etc. will be removed from our report and the transcripts.
- Elisabeth Fortier and Dr. David Malloy will have primary access to the data. Committee members, Dr. David Gregory, Dr. Elizabeth Fistein, and Dr. Rebecca Genoe may have access to de-identified interview transcripts to help confirm findings of the study.
- There are limits to confidentiality: as there is a risk of being identified due emails. To manage this risk your interview transcript will only contain de-identified information. Further, due to the critical inquiry nature of this research, take caution to not use your work email.
- Security measures take into account the nature, type and state of data: the data will be in the form of paper (consent forms & master list) and de-identified transcripts will be in a file on a password protected computer. The consent forms and master list will be stored separately from the data collected. These documents will be stored in the research supervisor’s locked office AD Hum 526.2 while the data collected will be stored in CKHS 145, Elisabeth Fortier and Dr. Malloy’s locked research office at the University of Regina.

Storage of Data:
- In transit from the interview location, the digital data is secured through a password-protected laptop computer, and recording device.
- The data will be stored in research offices CKHS 145 and Ad Hum 526.2 at the University of Regina. Long-term storage of research data after data analysis is complete will be undertaken by the research supervisor, Dr. David Malloy. The time duration of the storage is 7 years (until Spring 2024). After this time electronic files will be deleted and paper copies shredded.

Right to Withdraw:
- Your participation is voluntary; you may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.
• Should you choose to withdraw, please contact Elisabeth Fortier or Dr. David Malloy. In this case, your contributing data would not be included in the analysis of the study. The interview transcripts and audio recordings would also be destroyed.
• The right to withdraw from the study will apply until August 1st, 2017. After this date, it may not be possible to withdraw data contribution as the data may be pooled together and conclusions of the research will come from this.

Follow up:
• Each participant can find out the results of the study and will receive a poster or the findings of the study by email.

Questions or Concerns:
• Contact the researcher(s) using the information at the top of page 1;
• This research project has been approved on ethical grounds by the U of R Research Ethics Board on [insert date]. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office Phone: (306) 585-4775 and email research.ethics@uregina.ca.

Consent
Your signature below indicates that you have read and understood the description provided; I have had an opportunity to ask questions, and my questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

Name of Participant | Signature | Date

Researcher’s Signature | Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.
Appendix D: University of Research Ethics Board Approval

University of Regina

Research Ethics Board
Certificate of Approval

PRINCIPAL INVESTIGATOR
Elisabeth Fortier

DEPARTMENT
Kinesiology and Health Studies

REB#
2017-074

SUPERVISOR
Dr. David Malloy

TITLE
Moral Agency among Nurses: Urban and Remote-Rural Healthcare Culture

APPROVED ON:
June 2, 2017

RENEWAL DATE:
June 2, 2018

APPROVAL OF:
Application for Behavioural Research Ethics Review
Letter of Initial Contact
Participant Consent Form
Interview Questions

Full Board Meeting
Delegated Review

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms1/ethics-forms.html.

Dr. Katherine Robinson
Chair, Research Ethics Board

Please send all correspondence to:
Research Office
University of Regina
Research and Innovation Centre 109
Regina, SK S4S 0A2
Telephone: (306) 585-4775
Appendix E: Interview Questions

1. Can you tell me a little bit about yourself, your background? Why did you decide to become a nurse?

2. Can you recall a situation at work that touched you as a nurse? What happened? Why does this situation stand out to you? What is successful care to you?

3. What do you think it means to have a voice as a nurse?

4. What do you think it means to have autonomy as a nurse? How, if at all, do you advocate for patients? Can you give me an example?

5. As a nurse what would be an opportunity to show initiative in the workplace? Could you give an example? If not, can you give me an example of what you feel constricts you in your work?

6. Can you tell me about any organizational or structural barriers that you may face in your work as a nurse?

7. How would you approach a situation at work where you know what to do (for the best of the patient), but you feel prevented from doing what you think is right?

8. Can you tell me about your degree of freedom in making decisions as a nurse? Do you think your decisions have an impact on the care you provide? Why or why not?

9. Can you recall a situation where you were required or ordered to do something as a nurse that you disagreed with? Or regret?

10. Do you intend to stay in the nursing profession for the rest of your career? Do you trust the healthcare system?