

Moral Agency, Moral Imagination, and Moral Community:
Antidotes to moral distress, as reported by experienced ICU nurses regarding the
withdrawal of aggressive treatment

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Dedication

This thesis is dedicated to my mother, who instilled in me a passion for lifelong learning and by her example showed me what it looks like to live and die with grace and dignity.

“Anything worth doing is worth doing well.” - Maxine Scheneker Beck (1930-2013)

Abstract

Moral distress has been covered extensively in nursing literature and increasingly in the literature of other health professions. Cases that cause nurses' moral distress mentioned most frequently are those concerned with prolonging the dying process. Given the standard of aggressive treatment over comfort care that is typical in intensive care units, much of the existing moral distress research focuses on the experiences of ICU nurses. However, moral distress does not automatically occur in all end-of-life circumstances, nor does every ICU nurse suffer its damaging effects. What are the practices of these nurses? What specifically do they do to navigate around or through the distressing situations? The nursing literature is lacking in answer to these questions. The purpose of this qualitative, interpretative study is to fill in that gap. It uses narrative analysis to explore the reported practices of experienced ICU nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature. The findings are organized under three major themes: (1) moral agency, (2) moral imagination, and (3) moral community. Further, a total of eight subthemes are identified. The practices that constitute these themes and subthemes are further detailed and discussed in this thesis. Understanding these practices can help identify solutions to reduce ICU nurse moral distress.

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CHAPTER 1: INTRODUCTION

Statement of the Problem

Moral distress occurs when an individual, as a moral agent, feels constrained from doing what he or she believes is ethically the right course of action. It is a common problem in health care work, with negative consequences for nurses including psychological and physical exhaustion, decreased morale, and decreased job satisfaction.

Moral distress has been covered extensively in nursing literature. Cases that cause moral distress for nurses mentioned most frequently are those concerned with prolonging the dying process. Given the standard of aggressive treatment over comfort care that is typical in intensive care units, much of the existing moral distress research focuses on the experience of ICU nurses.

Although ICU nurses report moderate to high levels of moral distress overall, it does not automatically occur in all end-of-life circumstances. Since not every nurse experiences the damaging effects of moral distress, there is much to be learned from the reported practices of those who do not. The nursing literature is rich in identifying the presence of moral distress in ICUs and its damaging effects on nurses, but lacking in information about those nurses who manage to avoid or navigate through it. We do not know the practices of these nurses, nor what specifically they do to avoid the negative consequences. Understanding the practices of these nurses can help identify solutions to reduce ICU nurse moral distress, thereby improving the work environment and patient care.

Aim of the Study

The purpose of this study is to identify the practices of experienced ICU nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature.

Significance of the Study

This study will help to identify solutions to reduce ICU nurse moral distress.

CHAPTER 2: LITERATURE REVIEW

Moral distress – early research and definitions

The concept of moral distress was first introduced by philosopher Andrew Jameton in his 1984 book “Nursing Practice: The Ethical Issues.” Jameton wished to distinguish moral dilemmas, defined as situations of not knowing what is the right thing to do, from what is actually experienced when one’s beliefs on how to act is constrained. He defined moral distress as the feeling experienced “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6).

Wilkinson (1987) extended Jameton’s work by further exploring the phenomenon of moral distress as experienced by staff nurses working in hospitals. While Jameton’s definition referred only to the cause of moral distress, Wilkinson described the effects of moral distress on nurses. She conceptualized categories of moral distress, including situational, cognitive, feelings, and action components. She found that moral distress does not automatically occur when a certain type of case occurs, as nurses’ moral frameworks were more often based on consequences rather than rules. Her study indicated that both perceived and actual constraints prevented nurses from implementing their moral decisions. She defined moral distress as “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior of that decision” (p. 16).

Wilkinson’s 1987 study looked specifically at the kinds of cases that caused moral distress for nurses, and discussed both the types of situations and moral frameworks involved. The cases mentioned most frequently by the nurse subjects were those concerned with prolonging life. The moral issues mentioned most often were (1) harm to the patient in the form of pain and suffering, and (2) treating persons as objects, or dehumanizing them. Given these findings it is no surprise that much of the subsequent nurses’ moral distress research from 1987 forward focuses on experiences in ICU settings.

Rodney (1988) was one of the first to further moral distress research by examining the experience specific to nurses caring for dying patients in critical care settings. The results of her study found “senselessness” to be a central theme of ICU nurses’ perspectives on prolonging the dying process. She found that critical care nurses experienced corresponding moral distress that resulted in feelings including resentment, frustration, and sorrow.

Continued studies confirmed that the majority of clinical situations reported to cause ICU nurses to experience moral distress were related to end of life care, and highest levels of moral distress were found to be associated with providing aggressive treatment to patients not expected to benefit from that care (Elpern, Covert, & Kleinpell, 2005; Ferrell, 2006; Hamric & Blackhall, 2007; Mobley, Rady, Verheijde, Patel, & Larson, 2007). Sibbald, Downar, and Lawryluck (2007) reported that ICU nurses felt the reasons futile care was provided included family demands, lack of timely or skilled communication, and lack of consensus among the treating team. In moral distress situations related to end of life, nurses described negative consequences for themselves, patients, and families. For them, these negative consequences included psychological and physical exhaustion, decreased morale, and decreased job satisfaction (Wiegand & Funk, 2012).

While previous studies acknowledged both the institutional and individual components of moral distress, there was little written that offered theoretical explanation of how these components were related. Peter and Liaschenko (2013) studied moral distress within the context of feminist moral theory, concentrating on the work of Margaret Urban Walker and Hilde Lindemann. Feminist moral theory sees morality as a set of socially embodied practices that occur between people as they account to each other. Walker (1998) described moral identity as an accounting of what a person responds to, takes responsibility for, cares for, and values. Under this lens, Peter and Liaschenko (2013) described moral distress as “the response to constraints experienced by nurses specific to their moral identities, responsibilities, and relationships” (p. 337). Given the high relationship between moral distress and aggressive end of life treatment, one of their key

recommendations was to make efforts toward shifting the goal of health care away from prolonging life at all cost to the relief of suffering, a goal accomplished by health care professionals working together.

Death, dying, and decision making in ICU

Death denial in American culture makes death acceptance difficult and provides challenges to ICU nurses (Hinderer, 2012). The perception of death, dying, and end of life care in the ICU varies considerably between physicians, nurses, and family members (Levy et al., 2005; Festic, Wilson, Gajic, Divertie, & Rabatin, 2010). King and Thomas (2013) found that ICU nurses accepted the reality of death and expressed strong commitment to making it as comfortable as possible, despite critical care environments that foster a “paradigm of curing” rather than a “paradigm of caring.”

Care that will ultimately end in a “bad death” results in moral distress for the ICU nurse (Borowske, 2012). The Institute of Medicine defines a “good death” as “one that is free from avoidable distress and suffering for patient, families and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical cultural and ethical standards” (Field & Cassell, 1997, p. 24).

Hamric and Blackhall (2007) found that ICU nurses reported more frequent and higher moral distress as well as a more negative ethical environment than did physicians. Both groups were found to experience moral distress, with the highest source having to do with pressure to continue aggressive treatment where they did not believe it was warranted. However, nurses felt more intense moral distress based on a lack of input on end of life decision-making. They also reported lower satisfaction with quality of care and less collaboration with physicians (Hamric & Blackhall, 2007).

In a synthesis of the nursing literature from 1996 to 2011 on strategies in end of life decision making in acute care, Adams, Bailey, Anderson, and Docherty (2011) found three nursing roles: 1) information broker, 2) supporter, and 3)

advocate. Similarly, McMillen (2008) found the ICU nurses' role in caring for patients who have had their treatment withdrawn to include planting the seed, supporting the family, and being a patient advocate.

Kennard et al. (1996) found that more so than physicians, patients and their families perceive the ICU nurse as an important and influential member of the health care team regarding decision-making. Puntillo and McAdam (2006) found that ICU nurses value their contributions to end of life decision-making and want to have a more active role.

Families perceive communication as an essential component in end of life care (Norton, Tilden, Tolle, Nelson & Eggman, 2003; Boucher et al., 2010). Limerick (2007) determined ICU nurses to be in the most advantageous position to foster end of life decision making with surrogate decision makers, as they develop relationships, provide meaningful information, and foster understanding.

McMillen (2008) concluded it is imperative that ICU nurses are supported in the end of life decision-making role. The lack of established support mechanisms serves to isolate ICU nurses and promote their withdrawal in an effort to protect their own moral integrity (Gutierrez, 2005).

Moral distress in ICU nurses – frequency, intensity, causes, correlations, and consequences

Moral distress has a negative impact on the healthcare work environment. One study found that one in three nurses experienced moral distress (Redman & Fry, 2000). Another found that nearly 50% of nurses had acted against their consciences in providing care to terminally ill patients (Solomon et al., 1993).

ICU nurses reported experiencing moderate levels of moral distress overall. This experience adversely affected their job satisfaction, retention, psychological and physical wellbeing, self-image, and spirituality (Elpern, et al., 2005).

Gelinas, Fillion, Robitaille, and Truchon (2012) identified three categories of stressors experienced by ICU nurses: organizational, professional, and emotional. Organizational stressors included lack of a palliative care approach,

inter-professional mistrust and conflict, and lack of continuity in life-support and treatment plans. Professional stressors included lack of end of life competencies, difficulty communicating with families, and difficulty collaborating with the medical team. Emotional stressors included value conflicts, lack of emotional support, and dealing with patient and family suffering.

Todara-Franceschi (2013) reported a correlation between ICU nurses' perceptions of preparedness and ability to care for the dying and their professional quality of life. Based on the earlier conceptual work by psychologist and research scholar Beth Stamm (2002), Todara-Franceschi (2013) defined professional quality of life as that which "encompasses the feelings and perceptions that professionals have in relation to their work, whether they feel satisfied and happy doing what they do" (p. 185). She found that most (80%) critical care nurses did not feel their nursing education prepared them to provide quality care to the dying and their loved ones. This lack of education was found to contribute to negative changes in professional quality of life.

There are reported correlations between years of experience and moral distress (Elpern et al., 2005; Hinderer, 2012). The information is not conclusive, however. Elpern et al (2005) reported a correlation between intensity of moral distress and years of nursing experience, leading the authors to speculate that with increasing years in the profession the cumulative effect of distressing experiences increases as well. On the other hand, Hinderer (2012) found that increased years of experience with patient death was a major element in ICU nurses' coping skill. This lack of consensus may indicate other factors are overriding contributors to the experience of moral distress.

Nurse moral distress has consequences on both individual and institutional levels. On the individual level, moral distress can lead to burnout and abandonment of their profession (Gutierrez, 2005; de Lima Dalmolin, Lunardi, Barlem & Silveria, 2012). On the institutional level, nurses' high rates of turnover cause a reduction in quality of care, patient satisfaction, and the reputation of the institution (de Lima et al., 2012).

Reducing moral distress

Browning (2013) identified empowerment, commonly defined as the giving of power, ability, or authority, as a significant predictor of moral distress frequency in ICU nurses. She found those with higher perceived empowerment experienced moral distress less often. High psychological empowerment scores were positively correlated with age, years of experience, collaboration in end of life care conferences, and end of life education. Manojlovich (2007) identified three components of nurse empowerment: (1) a workplace that has structures necessary to promote empowerment; (2) a psychological belief in their own ability to be empowered; and (3) acknowledgement that there is power in the work that nurses do.

Closely related to the concept of empowerment is that of moral agency. Moral agency is commonly defined as an individual's ability to make moral judgment based on a commonly held notion of right and wrong and to be held accountable for their actions. Baggini and Fosl (2007) define a moral agent as "one who has moral responsibility, who can act morally or immorally and who can be judged to have acted well or badly on moral grounds" (p. 150). Raines (1994) provided a conceptual definition of moral agency as applied to nursing as "action by the nurse based upon self-embodied principles and knowledge to facilitate a perceived positive outcome for the patient, family, or society" (p.7).

Corley (2002) argued that nurses with moral imagination experience less moral distress. She described moral imagination as "that aspect of the imagination which potentially becomes active in the moral agent's attempt to consider what moral decisions to make" (p. 646). Johnson (1993) earlier defined moral imagination as "an ability to imaginatively discern various possibilities for acting in a given situation and to envision the potential help and harm that are likely to result from a given action" (p. 185). Scott (2000) argued that emotional sensitivity to other human beings allows the nurse to more accurately perceive the context and perspective of the patient, and concluded that active moral imagination is

necessary for accurate perception.

Aroskar (1995) envisioned nursing as a moral community, defined as “a community in which the welfare of nursing caregivers and patients is explicitly recognized as being interrelated and interconnected” (p. 134).

Hardingham (2004) argued that because human beings are essentially interrelated, both personal and professional integrity is relational in nature. She emphasized the importance of recognizing that nurses often feel they must compromise their moral integrity in order to maintain their self-survival in their professional environment, and advocated for a professional health care environment that pays special attention to the social relationships and institutional distributions of power.

Summary

Good end-of-life care is described as ensuring that the patient is as pain-free as possible, and that the patient’s comfort and dignity are maintained (Kirchoff et al., 2000). Good end of life care in the ICU is imperative, both to the benefit of the patient and their families and also as an antidote to nurse moral distress.

Moral distress has been recognized and studied for more than thirty years. For ICU nurses, the majority of clinical situations reported to cause moral distress are end-of-life care, and the highest levels of moral distress are associated with providing aggressive treatment to patients not expected to benefit from that provision. Given the high relationship between moral distress and aggressive end-of-life care, it has been argued that the goal of health care should be one of health care professionals working together in a shift away from prolonging life at all cost to the relief of suffering (Peter & Liaschenko, 2013).

Death denial in American culture makes this shift challenging. Perceptions vary between physicians, nurses, and family members. More so than others, ICU nurses accept the reality of death and are committed to making it as comfortable as possible despite the “paradigm of curing” rather than a “paradigm of caring” that is prevalent in critical care environments (King & Thomas, 2013).

ICU nurses' roles in both end-of-life decision-making and caring for patients who have had their treatment withdrawn include communication, supporting, and advocating. In the essential component of communication, nurses have an advantageous position with patient surrogates, as they develop relationships, provide meaningful information, and foster understanding (Limerick, 2007). Lack of support isolates ICU nurses and promotes their withdrawal in an effort to protect their own moral integrity (Gutierrez, 2005).

ICU nurses report moderate levels of moral distress overall. They report organizational, professional, and emotional stressors (Gelinas et al., 2012). There is a correlation between critical care nurses' perceptions of preparedness to care for the dying and their professional quality of life. Most do not feel their nursing education prepared them to provide quality care to the dying and their loved ones (Todara-Franceschi, 2013). The consequences are felt on both individual and institutional levels.

Since not every nurse experiences the damaging effects of moral distress, there is much to be learned from the reported practices of those who do not. Although rich in identifying the presence of moral distress in ICUs and its negative consequences for nurses, the literature is lacking in information about those nurses who manage to avoid or navigate through it. This study seeks to identify and clarify the specific practices of experienced ICU nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature.

In the next chapters I discuss the reported practices of a group of 19 ICU nurses representing four ICUs located in a large teaching hospital in the Midwestern United States, relative to the study's aim. Their shared stories and perspectives illustrate knowledge, skills, and wisdom that have implications for education, improved patient care through nurse mentorship and retention, and future research.

CHAPTER 3: METHODOLOGY

Research Design

A major finding of a study that examined the communicative work of ICU nurses was that the participants did not report experiencing the damaging effects of moral distress common to their environment as detailed in the nursing literature. The current study seeks to identify the reported practices of these experienced ICU nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature.

Narrative research interprets the meaning of actions and events experienced by individuals or groups in order to describe why something happened as it did (Polkinghorne, 1988). An understandable plot or story line is achieved by linking together actions and events, organizing them into a schematic whole. The overall plot is constructed by highlighting common actions and events, identified as subplots. A hermeneutic interpretive technique is used to analyze the data and create the story from narrative examples that construct the plots and subplots (Polkinghorne, 1988, 2007). These plots and subplots explain the overall story. Narratives from reported practices are valuable for illuminating actual practices that can inform future interventions.

Participants and Setting

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

Inclusion criteria for this study included a minimum of five years' experience, a work schedule of at least fifty percent time, being comfortable with dying patients and their families, and having excellent communication as well as

pain and symptom management skills. The average age of these nurses was 48, and critical care experience averaged 17 years. Thirteen of 19 participants (68%) reported they had no education in death and dying. The remaining six participants (32%) reported they had education in death and dying through continuing education programs. See Figure 1 for schematic diagram (Appendices, p. 53).

Data Collection

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

The data consisted of unstructured, audiotaped interviews conducted by the principal investigators and lasting approximately 90 minutes long. Each participant was asked the following grand tour question: “Tell me about stories where you were able to negotiate with families and physicians to get everyone on the same page regarding withdrawal of aggressive treatment.” In the interview process, particular attention was paid to the temporal structure of the narrative (Polkinghorne, 1988). The researchers followed the lead the participant provided, asking clarifying questions throughout the interview.

The research team used the consensual validation method (Hill, Thompson, & Williams, 1997) and unanimously agreed that the nineteen interviews provided more than sufficient data to answer the research aim. The interview data provided ample material for numerous thick descriptions. This richness of the data was used as the criteria for ending data collection.

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

Ethical Considerations

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

Data Analysis

The data were analyzed using a narrative, interpretive approach. The research team used the consensual qualitative research method (Hill et al., 1997), where each researcher analyzes the data independently. The focus of the analysis is interpretive, and discussion moves between the original data and the emerging description of the plot and subplots (Polkinghorne, 1988; Eberhart & Pieper, 1994).

My role in the analysis of the original data involved interpretation of the research findings. In the interpretive process it became clear that the nurse participants in the study did not demonstrate evidence of experiencing moral distress as described in the nursing literature. The verbal communication and stated practices relevant to this finding were identified and categorized. This subset content was further analyzed under the research aim. The actions and events that tell the story (plots and subplots) were identified and will be reported under three major themes and eight subthemes.

Rigor

Narrative researchers argue for acceptance of the validity of collected evidence and interpretation that is foundational to narrative analysis. The purpose of validation is to convince readers that the research assertions are strong enough

to be a basis for understanding human behavior (Bailey, 1996; Mishler, 1990; Polkinghorne, 2007). Polkinghorne (2007) argues that the researcher is responsible for ensuring that the participant's own voice is heard and the narrative is not primarily the interviewer's creation.

Lincoln and Guba (1985) proposed four criteria for establishing rigor in a qualitative study: 1) credibility, 2) dependability, 3) confirmability, and 4) transferability. In later writings, they established authenticity as a fifth criterion (Guba & Lincoln, 1994).

Credibility refers to confidence in the truth of the data and its interpretation (Polit & Beck, 2008). In this study credibility was achieved by the audiotaped interviews and their verbatim transcription. The professionally transcribed interviews were reviewed and further checked for accuracy by the researchers. The group dynamic ensured reflexivity, the process of examining both oneself as the researcher and the research relationship. Research team members made sure that one another's preconceptions did not influence interpretation.

Dependability refers to the stability of data over time and conditions. The inquiry must provide evidence that the findings would be repeated if the study were replicated with the same or similar participants in the same or similar context (Polit & Beck, 2008). In this study using the same interview guidelines, careful documentation in ATLAS.ti, and the use of memos maintained dependability for the inquiry audit purpose.

Confirmability refers to objectivity. The findings must prove to be the product of the inquiry and not researcher biases (Polit & Beck, 2008). In this study the group dynamic achieved confirmability. My fellow researchers/advisors both have expertise in qualitative analysis as a means of reaching consensus on the interpretation of findings. Intercoder checks were established, and a code list was developed and managed via ATLAS.ti.

Transferability refers to the extent to which the findings can be applied to other groups or settings (Polit & Beck, 2008). Transferability was maintained in this study when the researchers mutually agreed that a point of data saturation had

been reached. The team was no longer finding new information. Based on the narratives, thick, vivid descriptions were constructed and followed by illustrative data. It is the thick description in the findings that allow transferability to like contexts.

Authenticity refers to the extent to which the researchers fairly show a range of different realities. A text has authenticity if it enables the reader to vicariously experience what is being described (Polit & Beck, 2008). Authenticity was achieved in this study by the thick descriptions the narratives provided.

CHAPTER 4: FINDINGS

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

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

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

This study sought to identify the reported practices of experienced ICU nurses who are skilled at and comfortable in working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature. The findings are organized under three major themes: (1) moral agency, (2) moral imagination, and (3) moral community. Further, a total of eight subthemes, or specific practices, were identified. These themes and subthemes overlapped and were often intertwined. For example, the significance of the subtheme moral communication was evident in many other themes. The practices are also non-sequential and often circular. However, each theme is discussed separately for the sake of clarity.

These themes and subthemes are illustrated in Figure 2 (Appendices, p. 54), and further detailed below.

Theme One: Moral Agency

The nurses who participated in this study shared stories that demonstrated strong moral agency to facilitate positive outcomes for both patients and families. They consistently approach the ethical issues in their daily work in a caring manner with primary focus on loyalty to their patients and a willingness to challenge hierarchies. They held themselves accountable for their actions. The practices relevant to moral agency they reported and discussed are (1) self-awareness, including accountability for self and accounting for skill, and (2) advocacy.

Self-awareness.

I remember when I first started as a nurse and for the first five years when somebody would die, I'd just be so scared. And I feel terrible now when somebody dies, but I feel more at peace. There's more of a comfort level... And I think all that has come through experience; through palliative care, chaplains, and families. I've just grown through the years and they've taught me different things. (Elaine)

The nurses in this study understood and were able to articulate what it was about themselves that contributed to their skill and comfort working with families and physicians regarding the withdrawal of aggressive treatment. They knew the work of nursing, understood what makes them skilled in their profession, and knew how to get the work done. They demonstrated a clear understanding of their roles and responsibilities and held themselves accountable for their actions. They benefitted from their own experience as well as that of others.

The participants frequently cited the virtue of “wisdom” and the qualities of “confidence,” “maturity,” and “sensitivity” as important personal traits. Many indicated awareness that their own values and perspectives were not necessarily the same as others. As one nurse commented:

It's all in the maturity and sensitivity, and respecting that we all have different perceptions and values, and we don't always have

rights to put them onto other people. That's hard and it takes a lot of wisdom. (Irene)

Another participant shared the value of not just nursing experience, but also “life experience” and continued personal growth:

It's not even just experience at the hospital as a nurse; it's life experience as well. I think it is feeling more confidence about who you are, educating yourself, keeping up on skills and things like that. (Fran)

Accountability for self was an important component of the nurses' self-awareness. The stories they shared demonstrated their understanding of what it means to be a nurse and willingness to accept responsibility for what is under their care. This involved responsibility in two senses: (1) the professional knowledge and skills necessary to be a competent nurse, and (2) the knowledge and understanding of their own moral values.

The study participants demonstrated professional knowledge of what it means to be a nurse (care work) and knowledge of the issues raised in end-of-life circumstances in ICUs. They shared stories that illustrated willingness to take responsibility for their own positions relative to such circumstances.

Forming and maintaining positive relationships with physicians and other colleagues was an example of professional responsibility that is crucial for good patient care, as cited by one nurse who commented:

Just like you've got to have rapport with the patient, you've got to have rapport with your colleagues. So when I work with my social workers and the case managers and consulting doctors, I want to make sure that everybody has the information they need, that they're all treated respectfully and given respect for the job that they do to help the patient get what they need... It's critical that we all are doing it together, that it's not like us against them or what they do doesn't matter... I think we're more effective as a team than alone. (Ruby)

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

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

The nurses in this study knew their own values and perspectives, and understood that not all moral agents share the same perspective. They did not shift blame, nor shy away from "owning" their position in situations of moral uncertainty. As one nurse shared:

I realize not everybody's going to think like I do. There are going to be people who would accept a less quality of life than I would, and that's their choice. (Olivia)

Accounting for skill was another component of the participants' self-awareness. In addition to demonstrating a clear understanding of their personal and professional roles and responsibilities and holding themselves accountable, the nurses in this study were able to account for what specifically makes them skilled in their nursing profession. Many attributed their skill to longevity in their position and unit, and learning from repeated experiences. They value the sharing their experiences and learning from one another. They respond to feedback. One nurse explained:

Having a comfort level, being very close to someone you don't know, that most intimate moment when you're with someone maybe taking their last breath; how did I learn to do that except for with experience and time? I wasn't taught that. I had situations.

She continued:

Talking out loud sometimes is how you learn and also, because I share a story that reminds me of a story you're telling, then we learn from each other... We teach each other without knowing about it. We observe each other." (Irene)

Another nurse participant described the value of feedback in end of life situations, from which she learns and applies to future scenarios. She shared:

Obviously it's crappy when someone dies, so nobody wants to get to that point. But I've had a lot of feedback that people felt reassured in that particular situation. When you get that kind of feedback, that people felt reassured, you're like, "OK, yeah, I'm doing a good job. I like doing this." I take that feedback from other people and keep applying it to future scenarios that I have with patients. (Pam)

Advocacy.

Interviewer: *If you were teaching undergraduate students, what would you want them to learn from this (end-of-life) situation?*

Study participant (Anne): *I guess I'd want them to never forget that you are an advocate. You are the only one who can help these people... You may or may not succeed, but you're the only one who's going to fill that role.*

The nurses in this study saw advocacy as a key role for themselves. The advocate role included speaking to the family on behalf of the patient, and speaking to the medical team on behalf of the family. As the frequent expectation of families and medical teams in intensive care tends toward the pursuit of aggressive treatment in the absence of patient improvement, these ICU nurses often found themselves advocating for their patients by challenging others to consider a change of direction from aggressive treatment to comfort care. To accomplish this they skillfully ask questions, listen, and provide information,

consistently calling attention to the biographical life of the patient. The following nurse provided an example of advocating for the patient while speaking to the family:

I will remind them (the family) that this is about what Mary the patient wanted and what kind of things did Mary do? Was she real active? Was she this? Was she that? What would she think about being on a ventilator and in a nursing home for an extended period of time, if not for the rest of her life? (Anne)

Another nurse provided an example of advocating for the family while speaking to the medical team:

I think that most of the times our physician colleagues are a little slow to give up the fight sort of thing. We may see that, but it's kind of getting everybody on the same page – family and physicians – and I think that's what we do. We have the hard discussions with the families and with the physicians. We ask, "What about...?" or "The family is feeling this. Let's sit down and talk." (Fran)

Theme Two: Moral Imagination

The nurses who participated in this study had strong moral imagination. The stories they shared demonstrated their ability to discern various possibilities for acting, and envision the associated helps and harms in the context of considering withdrawal of aggressive treatment. The specific practices they discussed around moral imagination are: (1) ascertaining what the patient would want, (2) empathy, and (3) envisioning and facilitating moral possibilities.

Ascertaining what the patient would want.

...If they (the patient) knew that they were never going to go back home and we might not be able to get them off the ventilator, if

they're going to be on dialysis for the rest of their life, really what would they want us to do? (Irene)

It was morally important for the nurses in this study to determine their patient's preferences for treatment, keeping the biographical life of the patient central in the context of their physical deterioration. Through the stories they shared, they demonstrated the imaginative skill of ascertaining what the patient would want. The study participants showed strong loyalty to their patients, as indicated by their reported actions to ensure their patients' wishes for their lives and end of life circumstances were both understood and honored. They defended their patients' autonomy, reminding family members that they themselves are not responsible for the decision; they are simply a voice for their loved one.

In response to the question "How do you ascertain whether the patient has talked with their families before?" one nurse shared:

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

The following participant shared how she initiates a conversation to understand a patient's wishes:

As it becomes clear that we're in an end-of-life situation, this would be the point when they may be expressing concerns... So that's where I'll step in and say "Well, let's see what you know." And then I'll just remind them again that they are a voice, they are not a decision maker. I'm not asking them to decide what they would want; I'm asking them to tell me what they know the patient wanted. (Anne)

This same nurse further shares her strategy for communicating with a decision maker, gently reminding them of their surrogate role:

I think the most important thing is absolutely helping them to understand the concept that this is not their decision. It is not their responsibility. It should not weigh on them at all. They are simply a voice. They are simply voicing what the patient has either put in their living will or they've talked about at some point in time... You needn't go home and feel like "I pulled the plug." You didn't pull any plugs. You're merely giving me permission to do what they asked you to do, but you are not responsible for that choice. It was their choice. (Anne)

Empathy.

Think about how you would want to be talked to if it was your family member; if it was your grandma dying. Think about what information you would want. (Maria)

The participants in this study demonstrated their ability to figuratively put themselves in another's shoes, typically a patient or family member, and skillfully communicate that perspective. They frequently cited aggressive treatment situations in which they asked others "how would you feel if..." and "what would you want done if..." They shared stories that demonstrated reflective listening, offering back a speaker's idea to confirm their own understanding, thereby building trust, respect, and a safe environment conducive to decision making. One nurse shared:

I can't assume I know how they feel. I can't assume that they're having a hard time. I can't assume that this is the hardest day of their life. You have to look at it and ask in a different way; "it seems to me you're in pain. Is that what you're feeling?" You have to confirm or elicit what they're feeling... (Irene)

Another participant recalled an end of life situation for a dying cancer patient in her care. The family dynamic included estranged children and an alcoholic husband who was “unable to let go” in spite of the physicians’ recommendations to discontinue aggressive treatment. A nurse recalled the care conference and commented:

He (the husband) was ill too, but did everything he was capable of in taking care of her. I think the fact that he was recognized for that, and treated civilly and recognized for his care, went a long way toward helping him to be able to make decisions and hear what people had to say.

She continued:

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

Another nurse, who noted the important role of listening, shared a similarly empathetic perspective toward family members:

Sometimes I think we’ve been through this so many times, but it’s always that person’s first time, so just go in, not being all-knowing... like having a listening ear and empathizing with how difficult this must be. I try to put myself in their shoes – that family member’s shoes, and not say too much. Not to give too much advice, but just to empathize with how hard this must be. (Olivia)

Envisioning and facilitating moral possibilities.

Life and death are monumental times in people’s lives. It’s a privilege to be a nurse and to be able to be with family and amongst family and patients at this time. How many people get that

opportunity to be part of an end-of-life thing? It's a privilege. I would want people to think of it that way. (Maria)

It is difficult for families to make the decision to stop aggressive treatment and transition to palliative care. The nurses in this study saw alternate ways of viewing the reality of the patient's imminent death and sought to ensure that their patients' lives ended well and the death was morally acceptable and emotionally comfortable for the family. Their reported practices demonstrated skill in envisioning and facilitating moral possibilities; they were adept at communicating various imaginative scenarios to families, physicians, and one another. The following quote illustrated a participant's imaginative skill:

I guess it's how you want to view it. Do you want to view it that we can prolong your life or that we can prolong your suffering? We (ICU nurses) view it, a lot of times, as we can prolong your suffering. We would, quite often, choose to end this type of aggressive treatment much sooner than family members will. And even physicians sometimes too just don't quit. They are so aggressive and the prognosis is so poor. We wonder why? Is it prolonging their life? No. Is it improving the quality of their life? No. (Natalie)

One nurse reported that she liked to sit in on care conferences because "there are more than a few physicians who are not comfortable with end of life." She shared a dialog that invited a physician into the imaginative process of envisioning and facilitating moral possibilities to assist in the decision-making around continued aggressive treatment:

I don't want you caught unaware. I would much rather have you prepared for whatever, than expecting one thing and another happens and you're distraught because you never dreamt this could happen. I want you to imagine than any of these could happen. (Anne)

Theme Three: Moral Community

The concept of moral community is based on an understanding of moral agents being both personally and professionally interconnected, interrelated, and interdependent. For the nurses in this study the moral end sought was a good death. With a common goal of patient wellbeing, these nurses thought it was important for physicians to share in the pursuit of this moral end.

The nurses in this study indicated strong awareness of the importance of moral community and saw themselves as critical to the team process of decision-making regarding the withdrawal of aggressive treatment. They reported practices that recognized and positively utilized the relational nature of moral community. These specific practices they discussed relevant to moral community are (1) managing conflict, (2) supporting relationships, and (3) moral communicative work.

Managing conflict.

There is conflict at times. I can think of many, many times when one person is ready to quit, who is saying it's pointless and futile, when others aren't. On more than a few occasions it's been a youthful medical person who is just not as experienced. (Anne)

Conflict, the expressed struggle between at least two interrelated parties, is not inherently bad. In fact, in complex human groups conflict is inevitable and this is no less the case when moral stakes are high. Recognizing conflict, identifying its source, minimizing its impact, and managing the conflict to resolution were practices reported by the nurse participants. These experienced nurses saw the ever-present potential for conflict interference and were skilled at staving it off. They continually worked to achieve and maintain positive relationships with physicians and other team members. They saw communicative skill and patience as personal assets in conflict management.

The following participants shared their observations on differing viewpoints relative to the pursuit of continued aggressive treatment as a source of conflict:

There are families who, if you try to talk to them about the reality of the illness, any deterioration, or anything that has to do with [the patient] not living, they just don't want to hear it. All they want to do is keep going no matter what, even though you have conversations with them about quality of life. That gets difficult, and they get angry because we keep addressing it, family meeting after family meeting. (Bonnie)

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

The nurses in this study recognized conflict as inevitable, but did not see it as an insurmountable problem. They shared examples of everyday practices that demonstrated their skill in minimizing impact and managing the conflict to resolution.

Part of managing conflict is about understanding reasons for actions and determining if they make sense. To achieve this, the nurses utilized the communicative skills of asking questions in effort to understand the other person's perspective, and respectful listening. This communicative work enabled the nurses to protect and maintain relationships. One participant shared:

A lot of times I'll go in for the day and talk with the other nurse and I'll have a list of things I want to discuss with the physician. The most conflict we get is if I say "Did you consider doing this and this and this?" and they say, "I don't want to do this and this and this." I'll say, "I'd like to know why." (Then) they'll explain why. Most of the time everybody is pretty reasonable. (Lucie)

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

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

Another study participant recognized that families often need time to come to terms with the knowledge that their loved one is dying. She shared the value of patience in proactively managing potential conflict and “getting people on the same page:”

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

Supporting relationships.

End-of-life should be as pleasant and peaceful as you can possibly make it for somebody; not only for the patient, but also for the family. It’s a big joint effort. It’s not just a patient issue. It’s not

just a family issue. It's everybody involved, including the medical staff. (Pam)

Health work is very complex, and the ICU environment in particular requires extraordinary organization and coordination. For the nurses in this study, relationships were central to getting their work done well. "Supporting" was a word used frequently as they described themselves, their roles, and responsibilities relative to forming and maintaining relationships. In addition to their critical role of supporting patients and families, they noted the importance of supporting one another and the larger health care team.

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

So I think supporting the whole family, just sort of surrounding them with care and concern, is key. You are not treating one person, you are treating a family. We always want to consider things through the patient; what the patient would decide for their self if they could. But they don't live in isolation; they live as part of this family. So I think this (supporting the family) is extremely important. (Fran)

In addition to acknowledging the humanity of family members, this support helps the family make decisions that need to be made regarding the transition from aggressive treatment to comfort care.

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

I want her to know I've got her back. There's nothing stupid she can say. I'm here for her... I can't make everyone do things my way, and I wouldn't want that, because I don't think my way is always perfect. Wisdom is being able to support, acknowledge, and give comfort to someone who is struggling or doubting what they said and feeling like they made a mistake and try to look at all the pieces to that and help them learn from it. (Irene)

For several study participants, recognizing and supporting the skill of others was a way to establish and preserve moral community. One nurse shared:

The intensive care doctors are really good at talking to families about where the patient is at. I like to sit in on those family care conferences, so I can help reinforce that when the meeting is over. Either I can translate for the patient later on if they are thinking about something the doctor said that they didn't understand, or I can remind them too, "Remember, the doctor said this." (Maria)

Another stated:

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

Moral communicative work.

Isn't it incredible sometimes how much information we're providing to these families? They're looking to us to tell them how their loved one is doing. It's just so powerful. We can't take for granted that families lean on every word we say. That's why I think it's so important to speak wisely and lovingly about everything, even when you're being very factual. (Jenny)

A good death, one that is free from avoidable distress and suffering for patients, their families, and caregivers, is not possible without good communication. The nurses in this study demonstrated skill in moral communication; that is, the verbal and non-verbal social interaction that enhances one another's understanding of the moral situations they are in and informs moral

decision-making. They shared common practices that include establishing rapport, preparing for conversations, asking questions, active listening, giving reflective feedback, being clear, and knowing when not to speak. The following quotes from participants in the study illustrate:

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

I would say for me to facilitate good communication, I like to be prepared. I make a list of things I want to talk about with the physician, so I don't forget, because a lot of times they'll come through so quickly." (Lucie)

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

Just listen, go in with humility. Sometimes I think that we've been through this so many times, but it's always that person's first time. So just going in, not being all-knowing, but just kind of being...

like having a listening ear and empathizing how difficult this must be...Sometimes I think we can say too much. (Olivia)

Summary

The overall story told by the nurses' narratives in this study paints a picture of skilled, experienced ICU nurses who do not show evidence of experiencing moral distress. These nurses have strong moral agency, as demonstrated by their self-awareness and advocacy. They also demonstrate strong moral imagination, as evidenced by their ascertaining what the patient would want, empathy, and envisioning and facilitating moral possibilities. They perceive themselves to be an integral part of a moral community, as demonstrated by their reported practices in managing conflict, supporting relationships, and moral communicative work.

CHAPTER 5: DISCUSSION

Death ends a life in the physiological sense and also closes the story of a life in a biographical sense. Good end-of-life care, as the last chapter of the story, acknowledges the existential value of a life lived and coming to an end. For the nurses in this study a “good death” for their dying patients is the moral end sought.¹ When their scientific knowledge and experience informs them that the patient is going to die soon, they see it as a moral imperative to facilitate as good a death as possible. To do this they need to get to know the dying person and their families quickly, as a good death is not possible without a mutual understanding of what is happening.

Continued aggressive treatment in the absence of patient improvement is not consistent with the notion of a good death as these nurses understand it. They see it as a moral imperative to help families make the decision to transition from aggressive treatment to comfort care. Those who successfully meet the challenge of this imperative can navigate around or through the damaging effects of moral distress.

Since 1987 the nursing literature on moral distress has focused on ICU settings, as the preceding research found the cases that caused moral distress mentioned most frequently by nurse subjects to be those concerned with prolonging the dying process. The associated dehumanization and harm to the patient in the form of pain and suffering were the main moral issues reported.

Nearly thirty years later, moral distress in ICU nurses is still prevalent and of increasing concern. Much has been written on the subject, yet studies on interventions to reduce moral distress have been limited (Corley, 2002; Elpern et al., 2005; Epstein & Delgado, 2010; Hamric, 2012). Most studies have reported

¹ “One that is free from avoidable distress and suffering for patient, families and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical cultural and ethical standards” (Field and Cassell, 1997, p. 24).

factors that contribute to the experience of moral distress. Much less is known about factors that mitigate its effects (Hamric, 2012).

This study extends the nursing literature on moral distress by reversing the focus from what are the causes and implications for ICU nurses who care for dying patients and their families, to what are the reported practices of those who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment and do *not* show evidence of experiencing the damaging effects of moral distress. The nurse participants in this study reported skills and behaviors that function as safeguards against its negative consequences.

In this reverse process of studying those who do not suffer the damaging effects of moral distress as opposed to those who do, there were no major contradictions between the findings of the literature review and the new findings of this study. For example, a frequent source of ICU nurse moral distress cited in the literature is a lack of input on end-of-life decision making. The participants in this study saw themselves as moral agents with not just a key role but in fact a responsibility to facilitate end-of-life discussions. They reported practices that demonstrated skill in moral communication, the verbal and non-verbal social interaction that enhances understanding of moral situations and informs moral decision-making. They also indicated strong awareness of the importance of moral community and saw themselves as critical to the team process of decision-making regarding the withdrawal of aggressive treatment.

The nurses in this study are currently working in their units at least fifty percent time and have an average of 17 years of critical care experience. The context of their environment is not markedly different from ICU settings in other studies. It is safe to assume that these nurses do not see distressing aggressive treatment more, less, or differently than their counterparts in the literature who *do* report experiencing moral distress. The study nurses share characteristics and specific practices common to one another that demonstrated their ability to navigate through these distressing situations without the consequent moral distress.

Margaret Urban Walker (1992) defines virtues as “linked capacities to attend, describe, inquire relevantly, feel appropriately, and respond reliably to situations of a certain kind” (p. 33). By her definition, it seems appropriate to label the skills, behaviors, and specific practices of the nurses in this study as virtuous. These practices are the findings of this study, organized under the three major themes of moral agency, moral imagination, and moral community. Each theme is further discussed below.

Theme One: Moral Agency

The first antidote to ICU nurse moral distress is moral agency. Nurses must have agency in order to influence relationships and outcomes in their workplace. The nursing literature speaks much of “empowerment,” but little of moral agency. A primary component of nurse empowerment is a psychological belief in one’s own ability to be empowered (Manojlovich, 2007, Browning, 2013). Such belief requires rationality, autonomy, and limited self-interest, characteristics that philosophers and others have used to define moral agency (Rodney et al., 2013). By such definition, the concepts of empowerment and moral agency are clearly related. However, the author has strong preference for the latter term. Empowerment implies authorization or permission to act, where agency implies self-directed capacity or choice to act.

Raines (1994) proposed the concept of moral agency in nursing as “the action demonstrated by nurses who approach ethical dilemmas in a manner consistent with the caring component of nursing and with a focus on the patient” (p. 5). Rodney et al. (2013) further conceptualized moral agency as “rational and self-expressive choice, embodiment, identity, social and historical relational influences, and autonomous action within wider social structures” (p. 163).

As revealed in their narratives, the nurses in this study exemplified these conceptualizations of moral agency. They approached the ethical issues of their work in a caring manner with primary focus on loyalty to their patients. They demonstrated an understanding of what is was about themselves that contributed

to their skill and comfort in working with families and physicians regarding the withdrawal of aggressive treatment. They understood and owned their value systems, and further understood their own standing relative to other moral agents including family and fellow members of the health care team.

The nurses in this study also demonstrated moral agency in their communicative work. They shared stories of speaking with families and physicians to clarify the goals of patient care, consistently calling to attention to the biographical life of the patient relative to the consequences of continued aggressive treatment.

A study that measured the relationship between moral distress and psychological empowerment surveyed critical care nurses using the Psychological Empowerment Instrument (PEI) and found that nurses who perceived themselves as more empowered experience less moral distress (Browning, 2013). This finding was validated by the current study.

The nurse participants in this study saw themselves as active moral agents. They were reflective on what it was about themselves that contributed to their skill in working with families and physicians regarding the withdrawal of aggressive treatment, and used adjectives such as wise, mature, confident, and sensitive to describe themselves. They articulated the perceived value of both personal and professional experience, as well as continued learning and growth. This too is consistent with Browning's (2013) findings of significant correlation between empowerment and competence (the belief that one is able to carry out one's beliefs in action), self-determination (the sense that one has control over one's autonomy), and impact (the degree to which one perceives one's work as having influence).

Moral identity is an important component of moral agency. Walker (1998) described moral identity as an accounting of what a person takes responsibility for, responds to, is concerned about, cares for, and values. Moral identity requires self-awareness, particularly as it accounts for responsibilities and moral values.

The nurse participants in this study shared a common trait of what the author has termed “accountability for self,” that is, taking responsibility and holding themselves accountable in situations of moral uncertainty. The responsibilities they understood, accepted, and held themselves responsible for included both (1) the knowledge and skills necessary to be a competent nurse, and (2) the knowledge and understanding of their own moral values. This suggests the nurses in this study would have high psychological empowerment scores – and thus less moral distress – relative to the highest scoring PEI item reported in Browning’s 2013 survey, “I really care about what I do on my job.”

Previous studies have reported that exposure to death increases positive attitudes in some nurses and negative attitudes in others. There are reported correlations between years of experience and moral distress (Elpern et al., 2005; Hinderer, 2012). The information is not conclusive, however. Elpern et al (2005) reported a correlation between intensity of moral distress and years of nursing experience that led the authors to speculate that with increasing years in the profession the cumulative of distressing experiences increases as well. On the other hand, Hinderer (2012) found that increased years of experience with patient death was a major element in ICU nurses’ coping skill. The findings of this study validate the latter. The nurse participants were adept at accounting for their skill, and many of them attributed their skill to longevity in their position and unit and the repeated experiences from which they learn. They reported sharing their experiences and learning from one another.

Consistent with the findings in previous studies (McMillan, 2008; Adams, et al., 2011), advocacy was found to be a key role for the nurses in this study. Advocacy involves moral agency. The nurse participants reported specific practices that demonstrated skill in advocating for their patients by challenging family members and medical teams to consider a change of direction from aggressive treatment to comfort care. This finding is consistent in a reverse fashion with high-scoring PEI moral distress intensity items of “initiate life-saving actions when I think it prolongs death” and “follow family’s wishes to

continue life support when not in the patient's best interest" (Browning, 2013, p. 147).

Theme Two: Moral Imagination

The second antidote to ICU nurse moral distress is moral imagination. Pask (1997) described moral imagination as involving "the ability of the nurse to predict possibilities based on sound knowledge rather than unexamined 'handed down' belief" (p.208). Corley (2002) further defined moral imagination as "that aspect of the imagination which potentially becomes active in the moral agent's attempt to consider what moral decisions to make" (p. 646) and argued that nurses with moral imagination experience less moral distress.

The nurses in this study had moral imagination, made explicit in vivid descriptions of their specific practices relative to helping families transition from aggressive treatment to comfort care. These practices included ascertaining what the patient would want, empathy, and envisioning and facilitating moral possibilities.

Though their narratives, these nurses demonstrated imaginative skill in ascertaining what their patients would want. With a good death as the moral end sought, they used imaginative skill to ensure that their patients' wishes for their lives and end-of-life desires were both understood and honored. By reminding family members that they are not responsible for end-of-life decisions but rather simply a voice for their loved one, they defended their patients' autonomy.

Advocating for their patients and helping family members understand their surrogate role in end-of-life decision-making requires empathy. The Oxford English Dictionary (2015) defines empathy simply as "the ability to understand and share the feelings of another." Empathy goes beyond caring and compassion. Empathy identifies with another. The result of empathy is to vicariously experience the feelings, thoughts and attitudes of another person. In addition to the ability to predict possibilities based on sound knowledge, Pask (1997) argued that moral imagination involves the ability to distinguish between one's own and

another's views. The practice of empathy is thus intertwined with the previously detailed moral agency practice of self-awareness, particularly the understanding that not all moral agents share the same perspective, as discussed under the component of accountability for self.

The nurses in this study shared stories that demonstrated empathy. Not only were they able to figuratively put themselves in another's shoes, but also they were also able to skillfully communicate another's perspective. Relative to end-of-life situations, they frequently asked others "how would you feel if..." and "what would you want done if..." When families can see the biographical life of their loved one being respected and honored by the transition from aggressive treatment to comfort care, the likelihood of a "good death" – the moral end sought – is made possible.

Moral imagination requires not just the skill of being able to imagine various possibilities and their consequences, but the ability to morally evaluate the possibilities as well. The nurses in this study reported practices that demonstrated their ability to envision and facilitate moral possibilities with families, physicians, and one another that sought to ensure moral acceptability and emotional comfort regarding the patient's imminent death.

These findings validate Scott's (2000) theory that active moral imagination is necessary for accurately perceiving the perspective of the patient. The findings also validate Corley's (2002) theory that nurses who have moral imagination are less likely to experience moral distress.

Theme Three: Moral Community

Moral community is the third antidote to moral distress. Moral community is commonly defined as a group of people drawn together by a common interest in living according to a particular moral philosophy. It is based on an understanding of moral agents being both personally and professionally interconnected, interrelated, and interdependent.

Feminist health care ethics recognizes the work of nurses as embedded in complex social networks including health care professionals, patients, families, and administrators, further organized under political and economic structures (Peter & Liaschenko, 2013). The nature of teams is often hierarchical, with an uneven distribution of power. This imbalance is a contributing factor to nurses' moral distress.

The notion of healthcare environments as moral communities rather than hierarchical organizations has been increasingly recognized as imperative to good patient care and end-of-life decision-making (Aroskar, 2004; Hardingham, 2004; Austin, 2012). The American Nurse Association's Code of Ethics for Nurses with Interpretive Statements (2015) includes the recognition that "the complexity of health care requires collaborative effort that has the strong support and active participation of all health professions" (p.11), and "nurses ensure that all relevant persons, as moral agents, participate in patient care discussions" (p. 11).

In healthcare teams, the moral community is united toward a common goal of patient wellbeing. For the nurses in this study, a "good death" was the moral end sought. They shared stories that demonstrated a strong commitment to the importance of the healthcare team, including families and caregivers, working together to this end.

Conflict is inevitable in human relationships and can threaten moral community. The decision to withdraw aggressive treatment and transition to comfort care is often fraught with ambiguity and complicated by differences of personal and professional opinion. Conflict may ensue. Through their descriptive narratives, the nurses in this study demonstrated their ability to recognize conflict, identify its source, minimize its impact, and manage it to resolution. Their experience with conflict also made them skilled at staving it off.

The practice of managing conflict is intertwined with the skill of communicative work. A study that examined family member response to choices regarding the withdrawal of life support found conflict resulting from unmet information and communication needs (Norton et al., 2003). The data suggested

that the shift from aggressive treatment to comfort care was often perceived by families as abrupt and unexplained, contributing to conflict. The narratives shared by the nurses in this study would support that finding. However, these nurses utilized the communicative skill of asking questions and respectful listening in effort to understand family perspectives and needs in the face of decision-making regarding the withdrawal of aggressive treatment, thereby minimizing the potential for conflict.

The healthcare team can be an excellent source of support for its individual members. Austin (2012) argues that when team support is unavailable, the consequences can be described by words such as “lonely,” “betrayed,” “misunderstood,” and “ignored.” These and similar words and phrases are present in the literature that describes the consequences of moral distress on nurses at the individual level. “Supporting” was a word the nurses in the current study used to describe themselves, their roles, and relationships. They saw supporting others as a way to establish and maintain moral community, and therefore lessen moral distress.

Gelinas et al. (2012) found professional stressors experienced by ICU nurses to include difficulty collaborating with the medical team as well as difficulty communicating with families. The practice of moral communicative work is not only important to offsetting these stressors, it overlays nearly every other specific practice previously discussed.

Moral communicative work is more than just good communication. Moral communicative work is not simply the effective exchange of information, but rather the social interactions and behaviors that enhance one another’s understanding of the moral situations they are in and informs decision-making. Throughout the rich narratives they shared, the nurses in this study demonstrated skill in their moral communicative work, a practice worthy of its own recognition and integrated into all other reported practices as well.

Study Limitations

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

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

Moral distress as a problem for ICU nurses is well documented in the literature. Much has been written on the subject, yet there are no studies on nurses who do not demonstrate moral distress in situations where it is common. This study sought to identify the reported practices of experienced ICU nurses who are skilled at and comfortable working with families and physicians regarding the withdrawal of aggressive treatment without evidence of experiencing moral distress as described in the nursing literature.

These nurses reported practices of self-awareness and advocacy that demonstrated a strong sense of moral agency. In their efforts to help families and physicians make the transition from aggressive treatment to comfort care, they demonstrated empathy in seeking to discover what the patient would have wanted, and were able to envision and facilitate moral possibilities for a good death; characteristics of moral imagination. Transitioning to a good death requires the effort of multiple moral agents, specifically family, caregivers, and physicians. Critical to achieving this is a sense of moral community, which is sustained by the quality of relationships among moral agents. These nurses were skilled in moral communicative work that allowed them to manage conflict and support relationships to facilitate a good death, the moral end sought.

This was a self-selected group of nurses, noteworthy for their skill and comfort in working with dying patients. Their longevity in the units they worked in and their overall years of nursing experience was significant. Given that few had formal ethics education, I believe it is safe to assume that formal education had little impact on their ability to navigate around or through potential moral distress. Because these skills and behaviors are observable and identifiable, one can assume they are also replicable. The specific practices reported by the participants can be valuable in the development of ICU nurses who do not suffer the damaging effects of moral distress. This skill and knowledge development is

likely best achieved through mentorship of individual moral agents, and nurturing moral communities.

Healthcare teams are united toward a common goal of patient wellbeing. As the notion of healthcare environments as moral communities has been increasingly recognized as imperative to good patient care and end-of-life decision-making, the reported practices of the nurses in this study have implications for improved patient care through improved team processes. As moral distress adversely affects job satisfaction and nurse retention, mitigating the incidence can also presumably improve morale and reduce turnover.

Further research is warranted. The findings of this study validate the concepts and principles of both virtue and feminist ethics, and continued study under either lens is appropriate. Virtue ethics, which focuses on the development of character, acknowledges that individuals live in communities that significantly affect their character development. Consequently, virtue ethics holds individuals responsible for the kind of communities they collectively develop as well as developing their own good character. A virtue ethics approach to nursing does not ask “what as a nurse should I do?” but rather “what kind of nurse should I be?” (Volbrecht, 2002). The findings of this study provide an excellent framework for further examination and relevance of virtue ethics in critical care settings.

A feminist moral perspective, which sees humans as intrinsically relational and interdependent, emphasizes the values of connection, sharing, and community (Volbrecht, 2002). The findings of this study are equally valuable in providing illumination and exemplars for the relevance of feminist ethics in ICU settings.

Medical technology continues to introduce new opportunities to prolong life. As prolonging life can also mean extending the dying process, continued attention to moral distress is necessary. The nurses in this study exemplify commitment to a good death for patients and families, the moral end sought. Larger health care teams can learn and benefit from the knowledge gleaned from this study.

REFERENCES

- Adams, J. A., Bailey, D. E., Jr, Anderson, R. A., & Docherty, S. L. (2011). Nursing roles and strategies in end-of-life decision making in acute care: A systematic review of the literature. *Nursing Research and Practice*, 2011, 527834. doi:10.1155/2011/527834 [doi]
- American Nurses Association. (2015) Code of ethics with interpretive statements. Washington, D.C.: American Nurses Association.
- Aroskar, M. A. (1995). Envisioning nursing as a moral community. *Nursing Outlook*, 43(3), 134-138.
- Austin, W. (2012, March). Moral distress and the contemporary plight of health professionals. In *HEC forum* (Vol. 24, No. 1, pp. 27-38). Springer Netherlands.
- Baggini, J., & Fosl, P. (2007). *The ethics toolkit: A compendium of ethical concepts and methods*. Blackwell Pub.
- Bailey, P. H. (1996). Assuring quality in narrative analysis. *Western Journal of Nursing Research*, 18(2), 186-194.
- Borowske, D. (2012). Straddling the fence: ICU nurses advocating for hospice care. *Critical Care Nursing Clinics of North America*, 24(1), 105-116.
- Boucher, J., Bova, C., Sullivan-Bolyai, S., Theroux, R., Klar, R., Terrien, J., & Kaufman, D. A. (2010). Next-of-kin's perspectives of end-of-life care. *Journal of Hospice & Palliative Nursing*, 12(1), 41-50.

- Browning, A. M. (2013). CNE article: Moral distress and psychological empowerment in critical care nurses caring for adults at end of life. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, 22(2), 143-151. doi:10.4037/ajcc2013437 [doi]
- Corley, M. C. (2002). Nurse moral distress: a proposed theory and research agenda. *Nursing ethics*, 9(6), 636-650.
- de Lima Dalmolin, G., Lunardi, V. L., Barlem, E. L. D., & da Silveira, R. S. (2012). Implications of moral distress on nurses and its similarities with burnout. *Text Context Nursing*, 21(1), 200-208.
- Eberhart, C. P., & Pieper, B. B. (1994). Understanding human action through narrative expression and hermeneutic inquiry. *Advances in methods of inquiry for nursing*, 41-58.
- Elpern, E. H., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, 14(6), 523-530. doi:14/6/523 [pii]
- Empathy [Def. 1]. 2015. In oxforddictionaries.com/us. Retrieved August 8, 2015, from www.oxforddictionaries.com/us/definition/american_english/empathy
- Epstein, E. G., & Delgado, S. (2010). Understanding and addressing moral distress. *Online Journal of Issues in Nursing*, 15(3).

- Ferrell, B. R. (2006). Understanding the moral distress of nurses witnessing medically futile care. Paper presented at the Oncology Nursing Forum, 33(5) 922-930.
- Festic, E., Wilson, M. E., Gajic, O., Divertie, G. D., & Rabatin, J. T. (2012). Perspectives of physicians and nurses regarding end-of-life care in the intensive care unit. *Journal of Intensive Care Medicine*, 27(1), 45-54. doi:10.1177/0885066610393465 [doi]
- Field, M. J., & Cassel, C. K. (Eds.). (1997). Institute of Medicine Report: Approaching death: Improving care at the end of life. National Academies Press.
- Gélinas, C., Fillion, L., Robitaille, M., & Truchon, M. (2012). Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit. *CJNR (Canadian Journal of Nursing Research)*, 44(1), 18-39.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, 2(163-194).
- Gutierrez, K. M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, 24(5), 229-241.
- Hamric, A. B., & Blackhall, L. J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, 35(2), 422-429. doi:10.1097/01.CCM.0000254722.50608.2D [doi]

- Hamric, A. B. (2012). Empirical research on moral distress: issues, challenges, and opportunities. In *Hec Forum* (Vol. 24, No. 1, pp. 39-49). Springer Netherlands.
- Hardingham, L. B. (2004). Integrity and moral residue: nurses as participants in a moral community. *Nursing Philosophy*, 5(2), 127-134.
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The counseling psychologist*, 25(4), 517-572.
- Hinderer, K. A. (2012). Reactions to patient death: The lived experience of critical care nurses. *Dimensions of Critical Care Nursing: DCCN*, 31(4), 252-259. doi:10.1097/DCC.0b013e318256e0f1 [doi]
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice-Hall.
- Johnson, M. (1993). *Moral imagination: Implications of cognitive science for ethics*. University of Chicago Press.
- Kennard, M. J., Speroff, T., Puopolo, A. L., Follen, M. A., Mallatratt, L., Phillips, R., & Connors, A. F., Jr. (1996). Participation of nurses in decision making for seriously ill adults. *Clinical Nursing Research*, 5(2), 199-219.
- King, P. A., & Thomas, S. P. (2013). Phenomenological study of ICU nurses' experiences caring for dying patients. *Western Journal of Nursing Research*, 35(10), 1292-1308. doi:0193945913492571 [pii]

- Kirchhoff, K. T., Spuhler, V., Walker, L., Hutton, A., Cole, B. V., & Clemmer, T. (2000). Intensive care nurses' experiences with end-of-life care. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, 9(1), 36-42.
- Levy, C. R., Ely, E. W., Payne, K., Engelberg, R. A., Patrick, D. L., & Curtis, J. R. (2005). Quality of dying and death in two medical ICUs Perceptions of family and clinicians. *CHEST Journal*, 127(5), 1775-1783.
- Limerick, M. H. (2007). The process used by surrogate decision makers to withhold and withdraw life-sustaining measures in an intensive care environment. Paper presented at the Oncology Nursing Forum, 34(2) 331-339.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalist inquiry*. Beverly Hills, CA: Sage.
- Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Online Journal of Issues in Nursing*, 12(1).
- McMillen, R. E. (2008). End of life decisions: Nurses perceptions, feelings and experiences. *Intensive and Critical Care Nursing*, 24(4), 251-259.
- Mishler, E. G. (1990). Validation in inquiry-guided research: The role of exemplars in narrative studies. *Harvard educational review*, 60(4), 415-443.
- Mobley, M. J., Rady, M. Y., Verheijde, J. L., Patel, B., & Larson, J. S. (2007). The relationship between moral distress and perception of futile care in the critical care unit. *Intensive and Critical Care Nursing*, 23(5), 256-263.

- Norton, S. A., Tilden, V. P., Tolle, S. W., Nelson, C. A., & Eggman, S. T. (2003). Life support withdrawal: Communication and conflict. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses*, 12(6), 548-555.
- Pask, E. J. (1997). Developing moral imagination and the influence of belief. *Nursing ethics*, 4(3), 202-210.
- Peter, E., & Liaschenko, J. (2013). Moral distress reexamined: A feminist interpretation of nurses' identities, relationships, and responsibilities. *Journal of Bioethical Inquiry*, 10(3), 337-345.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.
- Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. SUNY Press.
- Polkinghorne, D. E. (2007). Validity issues in narrative research. *Qualitative inquiry*, 13(4), 471-486.
- Puntillo, K. A., & McAdam, J. L. (2006). Communication between physicians and nurses as a target for improving end-of-life care in the intensive care unit: Challenges and opportunities for moving forward. *Critical Care Medicine*, 34(11 Suppl), S332-40.
doi:10.1097/01.CCM.0000237047.31376.28 [doi]
- Raines, D.A. (1994). Moral agency in nursing. Paper presented at the Nursing Forum, 29 (1) 5-11.

- Redman, B. K., & Fry, S. T. (2000). Nurses' ethical conflicts: what is really known about them? *Nursing Ethics*, 7(4), 360-366.
- Rodney, P. (1988). Moral distress in critical care nursing. *Canadian critical care nursing journal*, 5(2), 9-11.
- Rodney, P., Kadyschuk, S., Liaschenko, J., Brown, H., Musto, L., & Snyder, N. (2013). Moral agency: Relational connections and support. Toward a moral horizon: Nursing ethics for leadership and practice, 160-187.
- Scott, P. A. (2000). Emotion, moral perception, and nursing practice. *Nursing Philosophy*, 1(2), 123-133.
- Self-awareness [Def.1]. 2015. In oxforddictionaries.com/us. Retrieved March 12, 2015, from www.oxforddictionaries.com/us/definition/american_english/self-awareness
- Sibbald, R., Downar, J., & Hawryluck, L. (2007). Perceptions of "futile care" among caregivers in intensive care units. *CMAJ : Canadian Medical Association Journal = Journal De l'Association Medicale Canadienne*, 177(10), 1201-1208. doi:cmaj.070144 [pii]
- Solomon, M. Z., O'Donnell, L., Jennings, B., Guilfooy, V., Wolf, S. M., Nolan, K., Jackson, R., Koch-Weser, D., & Donnelley, S. (1993). Decisions near the end of life: professional views on life-sustaining treatments. *American Journal of Public Health*, 83(1), 14-23.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: developmental history of the compassion satisfaction and fatigue test.

Todaro-Franceschi, V. (2013). Critical care nurses' perceptions of preparedness and ability to care for the dying and their professional quality of life. *Dimensions of Critical Care Nursing : DCCN*, 32(4), 184-190. doi:10.1097/DCC.0b013e31829980af [doi]

Walker, M. U. (1992). Feminism, ethics, and the question of theory. *Hypatia*, 7(3), 23-38.

Walker, M. U. (1998). *Moral understandings: A feminist study in ethics* (p. 36). New York: Routledge.

Wiegand, D. L., & Funk, M. (2012). Consequences of clinical situations that cause critical care nurses to experience moral distress. *Nursing Ethics*, 19(4), 479-487. doi:10.1177/0969733011429342 [doi]

Wilkinson, J.M. (1987). Moral distress in nursing practice: Experience and effect. Paper presented at the Nursing Forum, 23 (1) 16-29.

APPENDICES

Figure 1: Participants and Setting

Volunteer sample of 19 ICU nurses, representing four critical care settings of a large teaching hospital in the Midwestern United States, including neurological, medical, cardiovascular, and cardio-thoracic units:

Gender

- 19 female

Ethnicity

- 19 Caucasian

Age Range

- 31 to 61, with an average of 48 years

Years of experience in ICU

- 5 to 35, with an average of 17 years

Formal Education in Death and Dying

- Yes = 6 / No = 13

Degree in Nursing

- Associate's = 3 / Bachelor's = 15 / Master's = 1

Figure 2: Themes and Subthemes

