

**Risking Vulnerability:
Enacting Moral Agency in the Is/ought Gap in Mental Health Care**

by

Lynn Corinne Musto

MSN, University of Victoria, 2010

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

The Faculty of Graduate and Postdoctoral Studies

(Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

May 2018

© Lynn Corinne Musto, 2018

The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

Risking vulnerability: enacting moral agency in the is/ought gap in mental health care

submitted Lynn Musto in partial fulfillment of the

the
degree of Doctor of Philosophy

in Nursing

Examining Committee:

Patricia (Paddy) Rodney, Nursing

Supervisor

Rita Schreiber, Nursing (University of Victoria)

Supervisory Committee Member

Maura Macphee, Nursing

Supervisory Committee Member

Vicky Bungay, Nursing

University Examiner

Skye Barbic, Rehabilitation Sciences

University Examiner

Abstract

The definition of moral distress (MD) was put forward 35 years ago to explain the distress nurses felt when they experienced moral compromise. Making a moral judgment, enacting moral agency, and having constraints on agency have been identified as central to the experience. The known consequences of MD for health care professionals (HCPs), health care organizations, and patient care, are significant. Yet, researchers have struggled to develop meaningful interventions. The enactment of moral agency and constraints on agency are linked together in the experience. Constraints have been identified as being internal to the HCP, or external to the HCP and rooted in the context in which HCPs work. I argue that constraints on agency are dynamic (Musto & Rodney, 2016) and that gaining clarity on MD requires exploring the experience at the intersection of structure and agency.

I engaged in this study to explore how HCPs navigated ethically challenging situations in complex acute mental health settings. I conducted this research using grounded theory (GT) methods. Grounded theory (GT) methodology allowed me to focus on the processes participants engaged in when they confronted ethical challenges. The study was multidisciplinary, conducted across two urban acute care mental health sites. I gathered data through semistructured interviews and observation.

The basic social problem participants attempted to negotiate was *systemic inhumanity*, or the inability of the health care system to consistently extend respect, compassion, and dignity to individuals struggling with mental health

issues. The resulting model, *Risking Vulnerability: Enacting Moral Agency in the Is/Ought Gap*, explains how participants were able to act as moral agents in the particular context they were embedded in. Participants negotiated ethical challenges relationally, by *risking vulnerability*; that is, holding their professional obligations, clinical expertise, and organizational processes in tension with their own vulnerability in the system. This study highlights the importance for organizations to create a relational space in which HCPs are safe to explore ethical questions about how policies and practices may dehumanize individuals struggling with mental health issues. Thereby contribute to conflicts between care that is actually given (Is) and care that aligns with professional moral obligations (Ought).

Lay Summary

Moral distress (MD) occurs when health care providers (HCPs) are in situations where they experience an inability to practice a way that aligns with their professional values. MD arises when HCPs recognize an ethical conflict but are not able to take actions that may resolve the situation. The inability to take action may result from within the organization, such as shortages of resources affecting policies and practices, or from within the HCP from a lack of knowledge, or a lack of confidence. The purpose of this study was to explore how HCPs take action when they confront ethically challenging situations in mental health care. The findings demonstrate the importance of having organizational support so HCPs can explore ethical challenges and potential actions that can help them to practice in accordance with their ethical obligations and provide better patient care.

Preface

All of the work presented in this dissertation took place in the province of British Columbia. All research and associated methods were approved by the University of British Columbia's Research Ethics Board [Certification # H14-02595], and the Fraser Health Research Ethics Board [Certification #2015-074].

Three publications resulted from this research. Information from chapter 2 of this Dissertation was the foundation for Musto, Rodney & Vanderheide (2015) Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics*, 22(1), DOI: 10.1177/0969733014534879. I (Lynn Musto) was the lead author, responsible for approximately 50% of the content formation, and the manuscript composition. Dr. Rodney was involved with concept formation, contributed to the manuscript, and contributed to manuscript edits. Dr. Vanderheide also contributed to the manuscript by providing supplemental conceptual material.

Concepts from chapter 3 formed the foundation of Musto & Rodney (2016). Moving from conceptual ambiguity to knowledgeable action: Using a critical realist approach to studying moral distress. *Nursing Philosophy*, 17(2), doi: 10.1111/nup.12104. I was the lead author, responsible approximately 60% of the content formation, and manuscript composition. Dr. Rodney was involved with concept formation, contributed to the manuscript, and contributed to manuscript edits.

Concepts from chapter 2 formed the foundation for Musto & Rodney (2018). What we know about moral distress. In (C. Ulrich & C. Grady, eds) *Moral*

distress in the health professions. Springer Publication. I was the lead author, responsible approximately 60% of the content formation, and manuscript composition. Dr. Rodney was involved with concept formation, contributed to the manuscript, and contributed to manuscript edits.

I was the graduate student investigator for this research project and am responsible for all major areas of concept formation, data collection, and analysis, as well as the majority of manuscript composition. Dr. Maura McPhee was involved in the early stages of concept formation and contributed with manuscript formation. Dr. Rodney and Dr. Schreiber were involved throughout the project and contributed to concept formation and manuscript edits.

Table of Contents

Abstract	iii
Lay Summary	v
Preface	vi
Table of Contents	viii
List of Tables	xvii
List of Figures	xviii
List of Abbreviations	xix
Acknowledgements	xxii
Dedication	xxiv
Chapter One: Situating the Study	1
<i>Situating the Research</i>	2
<i>The Concept of Moral Distress</i>	3
<i>Challenges to the Definition of Moral Distress</i>	5
<i>Mental Health and Moral Distress</i>	9
<i>Challenges to Broadening our Conceptualization of Moral Distress</i>	11
<i>Focus of the Research Problem</i>	12
<i>Research Question</i>	15
<i>Overview of the Dissertation</i>	16

Chapter Two Literature Review.....	19
<i>Our Current Understanding of Moral Distress</i>	21
<i>Contributing Factors and Consequences</i>	23
<i>Canadian/British Columbia (BC) Health Care Context</i>	26
<i>Historical Context of Moral Distress and Bioethics</i>	30
<i>Moral Distress and Reciprocity</i>	35
<i>Moral Distress in Mental Health Care</i>	36
<i>Moral Distress and Patient Care in Mental Health</i>	38
<i>Summary of External Structures that Shape the Context of Care</i>	42
<i>Gaps in Our Knowledge: Reciprocity and The Moral Agent</i>	43
<i>Relationship between the Code of Ethics and Moral Distress in Mental Health Care</i>	44
<i>An Evolving Definition</i>	48
Making a moral judgment	48
The concept of constraints	50
The role of action	51
<i>Impact of Moral Distress on HCPs</i>	53
Exploring related concepts	56
<i>Relationship Between Moral Distress and Patient Care</i>	57
<i>Moral Distress Research in Mental Health</i>	59
<i>Summary of Conceptual Gaps</i>	61
<i>How Reciprocity May Shape Structures and Agents</i>	61
Embodiment	62

Embodiment and integration	64
Neuroplasticity.	66
Morality and neuroscience	67
Attachment	68
<i>Review of Interventions in Moral Distress</i>	70
Summary of interventions.	75
Organizations.	77
<i>Chapter Summary</i>	79
 Chapter Three Theoretical Framing	 82
<i>Exploration of Foundational Terms</i>	83
<i>Structure</i>	83
Structures as material and non-material	85
Structures as emergent	87
Structures as internal and external	88
<i>Moral Agency</i>	91
<i>Ontological Positioning</i>	93
Positivism	93
Post-Positivism	94
Constructionism	95
<i>Application of the Ontological Position</i>	99
Critical Inquiry	99
Relational Inquiry	101
<i>Methodological Application: Critical Realism</i>	105

<i>Bridging Post-Positivism and Constructionism</i>	110
<i>Toward an Ontology of Moral Distress</i>	114
<i>Methodological Pluralism in Critical Realism</i>	116
Generating Theory in Critical Realism.	117
Critiques of theorizing in critical realism	119
<i>Summary of Implications for Moral Distress Research</i>	122
Chapter Four: Methodology.....	125
<i>Review of the Research Problem and Questions</i>	125
<i>Situating Myself and the Research</i>	127
<i>Origins and Evolution of Grounded Theory Methodology</i>	130
<i>Historical Background</i>	130
The historical impetus for grounded theory.	130
Positivist grounded theory.....	132
Social constructionist grounded theory	133
<i>Contemporary Grounded Theory</i>	134
Constructionist grounded theory	134
<i>Summary of GTM for This Study.</i>	135
<i>Conducting Grounded Theory</i>	136
Inclusion criteria.	136
Exclusion criteria.	137
<i>Sampling</i>	137
Sensitizing concepts	138

<i>Sample Size</i>	139
<i>Location</i>	139
<i>Gaining Access and Recruitment</i>	140
<i>Data Sources</i>	142
<i>Participants</i>	142
Description of participants	143
<i>Data Collection</i>	144
Interviews	144
Participant observation	145
Document review	147
<i>Data Analysis</i>	148
Memoing	148
Coding	149
Constant comparison	151
Theoretical sampling	152
<i>Rigor and Evaluation of the Resulting Grounded Theory</i>	154
Reflexivity	155
<i>Ethical Considerations</i>	158
Informed Consent	158
<i>Confidentiality</i>	160
Researcher-Participant Relationship	161
<i>Dissemination of Findings</i>	162
Chapter 5 Findings.....	164

<i>Context of the Study</i>	166
Offloading responsibility for care	169
Safety and high-stakes situations	170
<i>Systemic Inhumanity</i>	171
<i>Risking Vulnerability</i>	174
<i>Working through Team Relationships</i>	178
Finding Boundaries	179
Strategizing actions	188
Fostering outside relationships	193
Summary	198
<i>Struggling with Inhumanity</i>	200
Rationalizing action	205
Distancing self	217
Living with bullying	222
Bullying from superiors	223
Bullying from peers	226
Bullying of patients	229
Focusing on the immediate relationship	234
Summary	240
<i>Pushing Back</i>	241
Holding fast to professional identity	243
Professional values guiding practice	245
Using shared clinical knowledge	247
Fostering collaborative organizational relationships	249

Taking strategic action	253
Relying on outside support	259
Accepting the consequences	263
<i>Summary of the Findings</i>	268
Chapter 6 Discussion	271
<i>Summary of the Study</i>	273
<i>Contributions to Knowledge</i>	275
<i>Structural Influences on Moral Agency</i>	275
<i>Exploring Complexity</i>	277
<i>Implications for the Definition of Moral Distress</i>	278
Constraints, moral agency, and context	279
Understanding the relationship between constraints and moral agency	279
Constraints on moral agency as an assault on HCPs' professional identity	282
<i>Systemic Inhumanity</i>	284
Humanity and inhumanity	286
The influence of perspectives of autonomy on the treatment of patients.....	286
Relational Approach to Care	289
The relational nature of agency within broader social structures	290
Societal structures that influenced care	291
The discourse of efficiency superseding the value of patient-centered care in decision-making	292
<i>Offloading Responsibility for Care, and Safety and High-Stakes Situations</i>	295
Increasing violence and antisocial behaviour	297
Worthy and unworthy mental health patients	299

Deinstitutionalization and reinstitutionalization through the criminalization of mental illness ..	301
<i>Political and Policy Tensions and the Influence of the Context of Care</i>	<i>308</i>
Values versus cost.....	309
Hollow policy	310
<i>The Role of Leadership.....</i>	<i>312</i>
<i>The Influence of Leadership on Moral Agency.....</i>	<i>313</i>
<i>Leadership and Policy</i>	<i>316</i>
<i>The Influence of Leadership Support in Situations of Unsafe Practice and Bullying</i>	<i>317</i>
<i>Team Influences on Moral Agency.....</i>	<i>322</i>
<i>Conclusion.....</i>	<i>327</i>
Chapter 7 Implications and Opportunities for Further Inquiry and Action	332
<i>Theoretical Implications</i>	<i>333</i>
Drawing on Theoretical Concepts from Across Disciplines	335
Power and Moral Agency	338
<i>Practice Implications.....</i>	<i>338</i>
Tipping in and out of Moral Distress: Influences	338
Leadership and the Creation of Space for Ethical Discussions	340
Clinical Supervision	342
<i>Implications for Education.....</i>	<i>343</i>
<i>Policy Implications</i>	<i>346</i>
<i>Research Implications.....</i>	<i>349</i>
<i>Limitations of This Study.....</i>	<i>350</i>

<i>Conclusion</i>	352
References.....	354
Appendix A Moral Distress Definitions.....	391
Appendix B Individual and Structures: Interactions.....	394
Appendix C Information Letter.....	395
Appendix D Interview Schedule	397
Appendix E Model	398

List of Tables

Table 1 Participant Characteristics	144
Table 2 Definitions of Moral Distress by Author/ Date	391

List of Figures

Figure 1 Risking Vulnerability: Categories of Action	165
Figure 2 Risking Vulnerability: Working through Team Relationships	178
Figure 3 Risking Vulnerability: Struggling with Inhumanity	200
Figure 4 Risking Vulnerability: Pushing Back	241
Figure 5 Risking Vulnerability	271
Figure 6 Interactions between Individuals and Structures	394

List of Abbreviations

APD	Antisocial personality disorder
BC	British Columbia
BPD	Borderline Personality Disorder
BSP	Basic social process
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CLBC	Community Living British Columbia
CMA	Canadian Medical Association
CTAS	Canadian Triage and Acuity Scale
DD	Dual diagnosis
ED	Emergency Department
EHS	Emergency Health Services
ER	Emergency
FASD	Fetal Alcohol Spectrum Disorder
FPH	Forensic Provincial Hospital
FTR	Failure to rescue
GT	Grounded theory
GTC	Grounded Theory Club
GTM	Grounded Theory Methodology
HA	Health Authorities

HCP	Health Care Professional
HEC	HealthCare Ethics Committee Forum
HR	Human Resources
HREB	Human Research Ethics Board
ICU	Intensive Care Unit
ID	Intellectual disability
MD	Moral distress
MDS	Moral Distress Scale
MDT	Moral Distress Thermometer
MH	Mental health
MHA	Mental Health Act
MHSU	Mental Health & Substance Use
MoH	Ministry of Health
MSE	Mental Status Exam
NICU	Neonatal intensive care unit
OD	Overdose
PCC	Patient Care Coordinated
PDD	Pervasive Developmental Disorder
PICU	Pediatric Intensive Care Unit
PRN	Pro Re Nata, meaning “as necessary”
PTSD	Post-Traumatic Stress Disorder
RN	Registered Nurses
SI	Symbolic interactionism

SR

Security room

Acknowledgements

I express my gratitude and appreciation to the health care professionals who agreed to participate to participate in this research. All the participants in this study discussed situations from practice that reflected their desire to provide care that aligned with their professional obligations to patients. They also expressed the desire to see changes across the acute care mental health system that ultimately supported the provision of care that extended dignity, respect, and compassion to individuals' struggling with mental health issues.

I deeply appreciate the support of my supervisory committee (Dr. Patricia Rodney, Dr. Maura MacPhee, and Dr. Rita Schreiber). My committee members have alternated between encouraging and supporting my academic endeavour, and challenging and pushing my thinking. They made themselves available to me in moments of crisis when I wanted to quit, and created external structure to keep me moving when I got stuck in the research and writing process. They are all generous scholars --generous with their knowledge, their time, and their expertise. Their involvement in my academic journey has shaped and changed me to my core. I cherish the example of mentorship that they have given me and hope to extend that generosity to students I have the privilege of mentoring in the future.

I also want to acknowledge the financial support I received from Canadian Institute for Health Research and from University of British Columbia (UBC) Faculty of Graduate Studies. Without this funding support, my graduate studies would not have been possible.

It has been a privilege to study at the UBC School of Nursing. I have had the opportunity to study with academic nurse leaders in Canada whose scholarship continues to shape healthcare policy and practice. I am also grateful for my fellow learners in the PhD program at UBC.

I also want to acknowledge the coolest club on the campus the University of Victoria, the Grounded Theory Club (GTC). I started attending in 2008, to begin learning about grounded theory. The GTC is made up of a dedicated group of scholars and life long learners who have greatly contributed to my growth as a scholar and a grounded theorist.

Finally, I could not have done this work without the ongoing support of friends and family. I want to thank my friends who have tolerated, and respected, my long absences from their social world. Yet, they warmly invite me back in when I have time. Foremost, I want to thank my family who have been on this long journey with me. Ian, who has literally been my cheerleader; Cora, who has reminded me of how proud she is of me and pushed me to completion; and my long-suffering husband Mark, who has steadfastly and unwaveringly supported me at each step of this journey. I love you all.

Dedication

To my family, Mark, Cora, and Ian. Without your support, this research would not be possible.

Chapter One: Situating the Study

I had been nursing for about five years and was working as a Psychiatric Liaison Nurse (PLN) in the ED when one day a woman came in seeking help. She expressed feeling hopeless and was worried that she was going to harm herself, as she had suffered a significant loss in the past six months and was having difficulty moving on after that loss. She had no plan to harm herself and had come to the hospital, because, she stated, she did not know where else to go for help. The ED physician certified the woman under the *Mental Health Act*. At that time, a draft policy existed that stated that all certified patients had to be stripped of their belongings, placed in hospital pajamas, and locked in the security room.

In my clinical judgment, this woman did not present an active suicide or elopement risk. I also believed that locking her in the security room was not in the best interests of the patient. In fact, I believed that the experience could potentially serve to increase her sense of isolation and hopelessness, adding to her mental health difficulties. I expressed my concerns to the physician and the head nurse and was told that if I did not comply with the draft policy, the security guards would be called in to assist another nurse in making sure the draft policy was followed. I complied with the order and the policy, but left my position in the ED within the next few months. This incident has stayed with me and prompted my entry into graduate studies in nursing.

Situating the Research

Although the story recounted above is from my own experience as a nurse, many health care professionals (HCPs) have similar experiences where they felt compelled to compromise their personal and professional values due to circumstances that they perceived as being beyond their control. This incident occurred approximately five years into my nursing practice and it became the beginning of an intentional journey in my personal and professional life. Although I could not articulate it at the time, this journey was about understanding the integral role of values in my life, and how I enacted those values as a nurse. The experience highlighted a series of questions that had been bubbling beneath the surface of my daily practice and related to how I lived out my professional obligations to the patients I cared for. Questions emerged for me such as: How do nurses provide compassionate care when they are pressed for time and have no privacy to talk about patients' concerns? How can nurses be a part of drafting policies that put the needs of the department before the best interest of the patient?

The questions I asked were accompanied by feelings of confusion, anger, sadness, and in this particular case, anguish, as I struggled to do what I believed was in the best interest of the patient. The intentional journey I began was embedded in a desire to understand what it meant to be a "good nurse." Initially, I attributed my struggles to a lack of clinical knowledge and believed that if I had more clinical knowledge and experience I would be able to answer such questions. As I grappled with these questions, I began to recognize the

conflicting values inherent in certain situations and I became exposed to the concept of moral distress (MD). I also began to wonder about how HCPs, such as myself, could be supported to work through situations and responses that led to the experience of MD, while continuing to act in the best interest of the patient.

The Concept of Moral Distress

The concept of moral distress resonated deeply within me. The original definition by philosopher Andrew Jameton (1984), in his study of nurses, stated that the experience arises “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6), as was certainly the case for me with the woman seeking help in the Emergency Department (ED). Interestingly, the key for Jameton (1993), in distinguishing a nurse’s story of MD from a story about a moral dilemma, was that he recognized that the nurse had already made a moral judgment about what was the right thing to do in that situation, subsequently experiencing distress (1993, p. 543). What makes this interesting is that it becomes apparent in his elaboration that it was the *emotional* component of the story that provided cues that something other than conflicting moral principles was taking place. However, Jameton did not explicitly connect his definition or ensuing explanation to the emotional or psychological aspects of the experience.

Despite the fact that the term moral distress named an important phenomenon for me at a crucial point in my career, I found that the definition put forth by Jameton (1984) was neither adequate to explain the depth of the

disturbance created by the experience, nor did it capture the complexity of the situation associated with MD. The definition of moral distress seemed linear and did not attend to the contextual factors that enabled and supported the institutional constraints. For example, the contextual factors that led to the development of the draft policy described in my story were subsumed under the broad category “institutional constraints” without an actual understanding of the reasons for the policy.

My experience led me to conduct a master’s thesis study at the University of Victoria on the experience of moral distress in mental health care. As I engaged in this research process, along with my subsequent doctoral studies at the University of British Columbia and my reviews of the evolving literature on the concept, I began to realize that the experience of MD was comprised of a complex and relational interplay between organizational and societal structures, and agents trying to act morally. For HCPs to act morally means to fulfill their moral obligations to patients by practicing in accordance with their Standards of Practice and Code of Ethics (Peter & Liaschenko, 2013).

In using the word “complex,” I am referring to all the attributes and processes that influence and shape human development and behaviour, as these factors influence an individual’s capacity for agency in a given situation. In the context of this dissertation, “factors” refer to the relatively fixed attributes in health care that shape behaviour, such as policy. “Processes” refer to the biological, neuro-physiological, and psychological developmental processes that are shaped by social structures, and the ideologies, and assumptions that

underpin these social structures. In using the term “relational” I am aware that it is used in the ethics and health care literature in two different ways. The first is in reference to interpersonal relationships (Bergum, 2013), and the second refers to how individuals are situated in a connected web of structural relationships in organizations and larger sociopolitical systems (Bergum, 2013; Doane & Varcoe, 2013; Rodney, Kadyschuk, et al., 2013; Sherwin, 1998). I elaborate further on my understanding of “relational” in Chapter Three in the discussion of relational inquiry. In the context of this dissertation, I am using the term “relational” to be inclusive of both definitions of relational, as I believe many of the challenges and critiques of the concept of moral distress are a result of the separation of the inter and intra-personal relationships from the contexts that shape these relationships (Musto, Rodney & Vanderheide, 2015).

Challenges to the Definition of Moral Distress

The concept of moral distress has also come to resonate deeply within the nursing community. Not long after Jameton’s initial work, nurse researchers began to apply the concept in specific nursing areas such as labour and delivery, critical-care, military nursing, nursing students, mental health, and medical/surgical units (Deady & McCarthy, 2010; Fry et al., 2002; Kelly, 1998; Ohnishi et al., 2010; Wilkinson, 1987, 1989). Challenges with the definition began to emerge immediately. The original definition, as conceptualized by Jameton (1984), was predicated on three main assumptions: (a) that nurses had made a moral judgment (b) that they did not act on that moral judgment, and (c) that

inaction was related to institutional constraints. Wilkinson (1987) was the first to refine the definition by explicitly acknowledging the psychological and emotional impact of the experience. Wilkinson's definition stated that moral distress is defined 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 behaviour indicated by that decision" (1988, p. 16). Also, although not explicit in her analysis, Wilkinson demonstrated that moral distress occurred even when nurses *did* take action. I consider that one of the flaws of the original definition is the assumption that nurses did not take action, because, although early research based on Jameton's definition clearly described nurses taking action, that action was not recognized as such (Jameton, 1993).

In response to Wilkinson's work, Jameton (1993) further refined his definition to include *initial* and *reactive* distress to decrease ambiguity. He stated that, "initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress" (p. 544). Although his refinement explicitly recognized the emotional aspects of the experience, Jameton maintained the assumption that moral distress is a linear experience with a cause (making a moral judgment), and an effect (not acting on that judgment). What Jameton also acknowledged with his refinement of the definition was that, in some cases, nurses *did* take action. However, there continued to be ambiguity in the definition in regard to nurses who did take action, yet still experienced moral distress.

As nurse researchers have worked with the concept of MD, the definition continues to evolve; yet problems remain. One of the main challenges currently raised by researchers is that the definition lacks conceptual clarity (McCarthy & Deady, 2008; Pauly, Varcoe, & Storch, 2012; Varcoe et al., 2012). Consequently, there is an uneven emphasis on different aspects of the definition (Hanna, 2004; McCarthy & Deady, 2008; Musto & Rodney, 2018; Musto, Rodney, & Vanderheide, 2015) in the research. For example, researchers point out that the definition lends itself to possible conflation between moral distress and psychological or emotional distress, leading to a call for researchers to focus on the *ethical* component of moral distress (McCarthy & Deady, 2008). Researchers have also questioned the idea of “constraints,” calling for further elaboration, because there is recognition that constraints internal to an individual *and* external constraints such as institutional policies may inhibit a person from taking action, or render his or her actions ineffective (Huffman & Rittenmeyer, 2012; Musto & Rodney, 2018; Musto & Rodney, 2016; Rodney & Varcoe, 2012; Webster & Baylis, 2000).

Although researchers continue to question and refine the definition of moral distress, they tend to use Jameton’s original definition as a foundation on which to build. The result is a growing list of definitions of moral distress without full clarification of the theoretical orientations and constructs that underpin the definition. Moving beyond this impasse is essential if we are going to develop interventions that will be effective in assisting HCPs as they work through moral conflict and meet their moral obligations. Scholars developing knowledge from

research outside the discipline of nursing can be the impetus necessary for understanding moral distress in new ways. Fortunately, there are promising fields of inquiry that can help. In the past two decades, advances have been made in our understanding of the depth of brain and body integration related to physical and emotional health (Doige, 2007; Narvaez, 2014; Siegel, 2012). There is also increasing recognition of the influence emotions can have on physical health and vice versa (Finset, 2012; Levine, 1997; Sapolsky, 2004). More recently, researchers in neuroscience have begun to speculate on the connection between morality and brain functioning (Bluhm, 2014; Greene, 2003; Killen & Smetana, 2008; Narvaez, 2014). Research being conducted across these disciplines points to a tightly intertwined and reciprocal¹ relationship between agents and structures (Musto & Rodney, 2016).

One further critique of the concept of moral distress is that research has largely focused on the nursing profession; this has led to the implied suggestion that nurses are the only HCPs that struggle with the issue (Hanna, 2004). Yes studies on MD are emerging across health care disciplines; for example, those in psychology (Austin et al., 2005), medicine (Hamric & Blackhall, 2007; Mack, 2013), physiotherapy (Carpenter, 2010), social work (Mänttari - van der Kuip, 2016) and pharmacy (Kalvemark Sporrang, Höglund, & Arnetz, 2006). These

¹ In the Oxford dictionary *reciprocate* has several meanings including “to give and receive mutually” and, as “part of a machine, to move forward and backward.” In using the term *reciprocity*, I draw on the idea that people are in a back and forth relationship with their environment and that they influence each other, although not always in a mutually beneficial way.

studies indicate that MD is experienced across disciplines; however, the circumstances that provoke the experience are different for each discipline. In initiating this study, I believed this information supported the need to broaden our perspective across professions and across disciplinary knowledge in order to bring conceptual clarity to MD. More recently, evidence has emerged indicating that health care managers also experience moral distress related to having to address competing responsibilities (Mitton et al., 2011).

Mental Health and Moral Distress

As noted above, critiques regarding moral distress include the understanding that it has been studied widely with nurses working in acute medical areas (Hamric, 2012). Just as research on MD has focused too narrowly on specific professions, it has also maintained a narrow scope on areas of practice. Thus, the area of psychiatry has largely been understudied in the context of MD (Austin, Bergum, & Goldberg, 2003; Deady & McCarthy, 2010; Nuttgens & Chang, 2013; Ohnishi et al., 2010). This being said, a (slowly) growing number of studies have been conducted in psychiatry in an attempt to identify the issues that give rise to the experience of MD, along with the barriers or constraints to action (Austin et al., 2005; Deady & McCarthy, 2010; Hamaideh, 2014; Musto & Schreiber, 2012). While these studies have added to our general knowledge base regarding MD, they also indicate that MD may also result from issues that are unique to mental health care delivery. Examples of some of these issues include coercion, restraint, enforced medication and the excessive use of

force (Deady & McCarthy, 2010; Musto & Schreiber, 2012). While not all nurses working in mental health experience MD as a result of using coercion (Lind et al., 2004), for those who do, the experience may have an effect on the quality of the therapeutic relationship between the HCP and their patient, and lead to the experience of MD. Given that HCPs' concerns are around quality of care delivery, the experience of moral distress may signal erosions in the quality and safety of patient care delivery (Rodney, Kadyschuk, et al., 2013).

To explore the concept of moral distress with the intention of integrating knowledge within psychiatry as well as other areas, it has been necessary for me to step back from Jameton's definition and examine it within the broader context of structures and agents, asking questions such as: What are the structures at play in promoting or ameliorating moral distress? How are they created, sustained, and changed? How do they shape/ influence society and values? (Rodney, Buckley, et al., 2013; Rodney, Kadyschuk, et al., 2013). I also needed to ask questions about moral agents; for example, what is the nature of moral agency—that is, HCPs' ability to act in a way that brings about a moral end goal? How do moral agents understand or develop values? How does someone demonstrate moral agency, particularly in the context of problematic structures? Such questioning is consistent with my understanding of relationships as inclusive of inter and intra-personal structures, as well as the contextual features that shape relationships (Musto, Rodney & Vanderheide, 2015).

Challenges to Broadening our Conceptualization of Moral Distress

There are challenges to broadening the definition of moral distress. These are (at least) twofold. First, when Jameton (1984, 1993) introduced moral distress as a moral judgment disguised as a moral dilemma, he firmly planted the experience within the confines of ethical theory. The result of rooting a deeply emotional experience within ethical theory is that the experience of MD, which begins with, or comes to, our awareness as a bodily experience, is now cut off from the body. Traditional ethical theory has historically viewed rationality as the way to working through ethical situations (Arras, 2010; Rodney, Burgess, et al., 2013). Although rationality is necessary for the examination of situations fraught with conflicting values and ethical principles, it is not sufficient for understanding or making decisions laden with emotional angst (Damasio, 1994).

Second, a concern with ethical theory is that it has developed largely in isolation from other disciplines, such as moral development and neuroscience (Flanagan, 1991, 1996). Such disciplines could shed light on an individual's ethical decision-making processes. Both of these challenges have constrained the efforts to develop a comprehensive understanding of concepts that underpin MD and how we enact our moral agency. Without a clearer understanding of MD that incorporates diverse theoretical orientations, it is difficult to develop or evaluate interventions that are effective in helping HCPs work through the experience.

Focus of the Research Problem

Reflected in the newer literature on MD, including publications that resulted from a symposium on moral distress (HEC Forum, 2012), is the desire of many clinicians and researchers to move forward with actions that support HCPs to ameliorate the experience of MD and that can create change in the broader sociopolitical structures that inhibit ethical practice (Hamric, 2012; Musto et al., 2015; Musto & Rodney, 2016; Rodney, Buckley, et al., 2013; Varcoe et al., 2012). The desire to move toward action is understandable, given that research findings suggest that there are links between and among the experience of MD, patient outcomes, short and long-term impacts on staff, and the effect of staff turnover on patient care (Epstein & Hamric, 2009; Hyatt, 2017; Webster & Baylis, 2000; Wilkinson, 1987).

As well, given that MD generates significant issues in terms of its impact on attrition and intention to leave (Austin, Saylor, & Finley, 2016; Sauerland et al., 2014; Whitehead et al., 2015), both practitioners and researchers have begun to call for interventions that will help HCPs manage the experience without suffering long-term consequences. Researchers are also pointing to the importance of viewing MD as a broader organizational issue (Hamric, 2012; Milliken, 2018; Pauly et al., 2012). However, knowing how, where, and which actions might be most effective becomes difficult when the concept of MD itself lacks conceptual clarity and also lacks sufficient theoretical grounding to frame subsequent actions. Taking action in order to develop interventions becomes

even more complex when we begin to consider interventions that include both structures *and* agents.

The anecdote recounted at the beginning of this chapter points to the complexity of the experience of MD and the interplay between structures (the ED and policies), and agents (myself and others involved in the incident). As such, it serves as an entry point into the process of this dissertation. The first step in exploring how the interplay between structure and agent influences moral distress is acknowledging that I view moral distress as embodied.² In approaching MD as an embodied experience, I attended to the reciprocal relationship between agents and structures. Bergum (2013) tells us that, “[e]mbodiment calls for healing the split between mind and body so that scientific knowledge and human compassion are given equal weight” (p.132). In a similar way, I sought to connect the felt (sensory) experience of MD in the body with the

² In taking the position that moral distress is an *embodied* experience, I am referring to how individuals take in and make sense of information as they navigate living in the world. We take in information about the world around us through our senses and neurobiological processes influence how individuals make sense of incoming information. Damasio (1999) refers to the separation of mind and body in science as “the lack of an *evolutionary perspective* in the study of the brain and mind” (p.39). Damasio is referring to how the brain processes information beginning outside of awareness with the areas of the brain responsible for maintaining homeostasis. Over the past 20 years, researchers have started incorporating an evolutionary perspective into different areas of study, e.g. attachment and moral development, to provide comprehensive explanations for the dynamic nature of the environment-brain-body relationship. Rushton et al. (2013) provide an example of taking an evolutionary, embodied perspective in their work on moral distress. For examples from the areas of attachment and moral development, readers are referred to Siegel (2012) and Narvaez (2014). I pick up this discussion of embodiment in chapter two.

theory that underpins the experience. Understanding MD as an embodied experience inseparable from the context in which we work provided a comprehensive, integrated approach to inquiry into the experience. It is my hope that this will move us further toward clarity in our theoretical orientation and constructs within, and across, health care practice contexts.

I have also worked toward an embodied understanding of MD so that it might contribute to insights into how the brain and body together experience a violation of moral boundaries³. Due to the lack of conceptual clarity, our current approach to the development of interventions is a trial and error approach whereby researchers trial an intervention but are unable to say with any certainty if, or why, the intervention was effective (Beumer, 2008; Källemark et al., 2004). Knowledge gleaned from conceptualizing MD as embodied may set the stage for thoughtful interventions specific to the experience. Throughout, it is my premise that understanding the concept of MD requires researchers to understand the agent as a *whole* being in the context of the structures in which he or she is situated (Musto et al., 2015).

³ Guthrie and Gabbard (1993) defined a violation as the harmful crossing of a boundary. They suggest that a boundary crossing may or may not be harmful depending on context and situation facts. By extending this idea to include morals, I am suggesting that the harm resulting from a moral boundary violation may be moral distress.

Research Question

In initiating this study, I proposed that appreciating the experience of moral distress as an embodied experience that encompasses a reciprocal relationship between health care structures and agents will help bring clarity to our understanding of MD. I further argued that this will be helpful in all areas of health care, in particular, the areas that are understudied such as mental health. Finally, I argued that this could be accomplished by examining how health care professionals enact their moral agency within the health care structures where they work. The specific research question I hoped to answer was:

How do HCPs in mental health navigate morally charged situations and enact their moral agency within their health care organizations?

This research question was directed at understanding what occurs at the intersection of structure and agency as HCPs seek to practice in alignment with their Standards of Practice and Code of Ethics. Toward this end, I conducted a qualitative study for this dissertation, with the aim of discovering how HCPs enact their moral agency within their immediate work environment of mental health care. Conducting qualitative research allowed me to explore with the participant the processes they engaged in, along with how the immediate context both supported, and at the same time inhibited, moral agency. As well, I examined participants' perceptions of how broader health care structures, such as policy and ideology, influenced the enactment of their moral agency. More specifically, I undertook a grounded theory (GT) study that resulted in a substantive theory that

explains the embodied processes mental health care providers engage in when they encounter morally distressing situations.

Overview of the Dissertation

This dissertation has seven chapters in total. In this first chapter I have presented a brief overview of the definition of moral distress and identified the gaps in our understanding of the concept of MD. I also presented some of the reasons for these gaps and the potential means to reconcile them within the context of mental health care.

In Chapter Two I explore the underlying constructs of MD within a broader disciplinary context. I present a more comprehensive overview of the relevant literature on MD, identifying the strengths and gaps in research related to mental health. As well, I touch upon historical debates in the literature related to moral psychology and moral development, and the current debates related to morality and neuroscience. I discuss how the implications of current debates may move us toward clarity in understanding MD. Drawing on literature related to the relationship between agents and structure, I integrate this literature and present a coherent argument for examining the reciprocal and dynamic relationship that exists between structures and agents.

In Chapter Three I discuss critical realism and constructionism, as they provided the conceptual foundations for framing my approach to this research. I examine how a critical realist perspective allowed me to attend to complexity in the experiences of MD in mental health care. It is my contention that using a

constructionist perspective enabled me to explore the meaning of moral situations with participants. This allowed me to better understand how participants made sense of their moral obligations and what influenced their actions as moral agents.

In explicating my research methodology and methods in Chapter Four, I present an historical overview of GT methods, moving from traditional GT to contemporary constructionist applications. The key tenets of GT are discussed along with the rationale for my choice of GT methods for the research. Details regarding the processes I used to conduct the research are provided, including information about recruitment and sampling; inclusion and exclusion criteria; rationale for the selection of sites; methods for data collection and analysis; ethical conduct of the research; and dissemination of findings.

In Chapter Five, I present the findings of this GT study, which resulted in the theory addressing vulnerability, moral agency, and moral distress. In Chapter Six, I discuss the key findings in the context of the extant literature. I begin by discussing how the findings influence our understanding of the definition of moral distress and moral agency. Finally, in Chapter Seven, I outline implications directed at supporting HCPs' enactment of moral agency in order to practice in alignment with their professional obligations to society. I also present suggestions for further theoretical development of the concept of moral distress. Practice implications focus on the importance of leadership in creating space for discussions on ethical issues. Educational implications include ethics education that includes both laying a foundation for ethical practice, and teaching students

to develop moral resilience. I argue this education should also include interprofessional ethics education. Lastly, I discuss policy implications, and suggestions for further research.

Chapter Two Literature Review

Understanding individual psychologies and the social forces that shape them are important tasks for ethics. It is one thing to determine what, ethically and politically, people ought to do, yet another to grasp the conditions under which they are likely to recognize what they should do, summon the motivation to do it, overcome inhibitions and obstacles to doing it, and in the end do something like what is required.

Margaret Urban Walker (2004)

In this chapter, I explore conceptual and empirical work to move toward a broader conceptualization of moral distress—a conceptualization that enabled me to set the stage in my dissertation research for inquiry that informed the development of the intentional, measurable, and ultimately effective, interventions I suggest in Chapter Seven. As I indicated in Chapter One, my research question was directed at understanding what occurs at the intersection of structure and agency as HCPs seek to enact their moral agency and practice according to their Standards of Practice and Code of Ethics. I took this approach for two reasons: the first was that Jameton (1984) definition of moral distress inextricably links the action or inaction of the agent to the context in which he or she works. The second reason was the possibility that illuminating the reciprocal influence between structure and agent could help clarify the ambiguities that exist within the definition I noted in Chapter One. It is my premise in this dissertation that, by clarifying the ambiguity underlying moral distress, we can move toward a comprehensive and coherent understanding of the concept—an understanding

that is ultimately a prerequisite to the future development of interventions that will support HCPs in the delivery of ethical care.

I begin Chapter Two by providing a broad overview of moral distress (MD). In advocating for an understanding of MD that recognizes the mutuality that exists between structures and agents, it is also helpful to sketch a picture of the current landscape of health care delivery. Toward this end, I provide an overview of the health care context in Canada and British Columbia. I then discuss the broader global climate that is reflective of, and impacts decision-making in, health care at a local level, particularly in mental health. I move on to explore the historical background that prompted Jameton to identify moral distress, then proceed to deepen my exploration of the literature noted in Chapter One, by focusing on research on MD in mental health more specifically.

In the section that follows the historical background, I investigate MD, keeping the moral agent at the center of the examination. I explore how an inadequate conceptual clarity makes it difficult to distinguish moral distress from other forms of distress, including, but not limited to, burnout⁴ or compassion fatigue. I also discuss the lack of conceptual clarity with regard to the ideas that make up the definition of moral distress, such as making a moral judgment, the role of action, and the idea of 'constraints.' Throughout the discussion, I identify

⁴ Burnout in nursing results from prolonged, high levels of stress at work and leads to a state of emotional, physical, and mental exhaustion, depersonalization of people in their care, and decreased person accomplishment (Schaufeli & Taris, 2005). The term compassion fatigue can result as part of the emotional cost of caring for others, and the resulting behaviours include chronic fatigue, irritability, dread of going to work, and a lack of joy in life (Potter et al., 2010).

gaps in our understanding of moral distress and how these gaps have inhibited the development of interventions. I then engage in a discussion of the moral agent, centering on the area of mental health and drawing specifically on research studies examining moral distress in mental health settings. Finally, I sketch a picture of the reciprocal relationship between structures and agents, drawing on an understanding of agents as embodied, and bringing in research from neuroscience and attachment. I conclude this chapter by pointing to the conceptual framing that supports an exploration of MD by focusing on the processes that occur between structures and agents, with the intention of developing conceptual clarity. Throughout this chapter I draw on local and international examples, highlighting the reciprocity between HCPs and health care structures. I also highlight research indicating that structures and agents can influence each other in positive ways. In discussing my research findings in Chapter Seven, I return to the literature reviewed in this chapter to explore the implications in terms of the GT I have developed.

Our Current Understanding of Moral Distress

The identification of moral distress arose out of a context of rapid changes in health care related to advances in technology, re-structuring of health care delivery, and sociopolitical and cultural changes occurring in the United States (Jameton, 1984). Central to the importance of naming moral distress was a recognition that being thwarted from enacting the values that underpinned health care practice could have significant consequences for HCPs. Identification of MD

originated in nursing, and subsequently, much of the research to date has been conducted within the discipline of nursing (Deady & McCarthy, 2010; Pauly et al., 2012; Whitehead et al., 2015; Wocial et al., 2017). However, more recent research on the concept has been conducted across disciplines and within interdisciplinary teams (Burston & Tuckett, 2013; Dodek et al., 2012). As I discussed in Chapter One, an evolution of the definition occurred as researchers worked with the concept and confronted some definitional difficulties. I elaborate on these difficulties later in this chapter.

In Chapter One, I showed that understanding moral agency as shaped by context is important for my research. Varcoe et al. (2012) offer the definition of MD as being

the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience⁵ shaped by multiple contexts, including socio-political and cultural context of the workplace environment. (p. 59)

However, missing from this definition is the dynamic nature of decision-making given the reciprocal relationship between moral agency and the context in which HCPs work. Throughout this dissertation, I build an argument for the importance

⁵ I make a distinction between how individuals shape, and are shaped by, relationally and through reciprocal relationships. In Chapter One, I described my understanding of “relational” as referring to both interpersonal relationships and how individuals are situated in a connected web of structural relationships in organizations and larger socio-political systems. When I use the term reciprocal, I draw on the idea that people are in a back and forth relationship with their environment and that they influence each other.

of understanding MD as a consequence of the reciprocity between structures and agents with the intention of moving toward interventions. I do this by identifying gaps in our understanding of the concept and draw on research from neuroscience, attachment, and embodiment as a potential means for adding to our knowledge. I then reconcile that knowledge with my findings.

Contributing Factors and Consequences

As our understanding of moral distress continues to evolve, there is growing recognition that the experience may have significant psychological and physiological consequences for HCPs and the health care system (Huffman & Rittenmeyer, 2012; Humphries & Woods, 2016; Rushton, Caldwell, & Kurtz, 2016; Wilkinson, 1987). In an overview of the literature on moral distress by Burston and Tuckett (2013), the authors separated the consequences of the experience into three categories: outcomes toward the self, outcomes toward others, and outcomes toward the system. In describing outcomes toward the self, Burston and Tuckett (2013) found that participants identified feelings of anger related to their inaction or inability to create change. Consequently, some of the experiences nurses described included, but were not limited to, anticipatory dread, diminished self-confidence, and self-doubt; experiences that resulted in feelings of hopelessness, helplessness, a diminished sense of purpose, and professional disillusionment. Outcomes toward others included the expression of anger toward others, and a sense of powerlessness over treatment decisions. In these situations, the nurse risked becoming callous and bitter, or cynical. Finally,

in synthesizing research that described outcomes toward the system, Burston and Tuckett (2013) found that when the morally correct course of action became impossible to pursue, nurses took no direct action at all, avoided conflict about the situation, or began to avoid the patient. A further consequence of these outcomes was that in some cases, nurses decided to leave the profession altogether. Evident in this list of outcomes is the negative impact that the experience of MD can have on nurses and other HCPs, patients, and the health care system.

Contributing factors to the experience of MD include contextual factors such as sociopolitical contexts that influence funding, health care delivery models that focus on efficiency, and neoliberal ideology that governs health care reform (Rodney, Kadyschuk, et al., 2013; Rodney & Varcoe, 2012; Varcoe et al., 2012). Lack of access to decision-making regarding patient treatment plans and resource allocation, along with hierarchical relationships within health care organizations, and the overall ethical climate, all may contribute to the experience of moral distress (Burston & Tuckett, 2013; Pauly et al., 2009). Prominent examples of lack of access to decision-making that lead to MD include participation in treatment planning in end-of-life care (Heyland et al., 2010; Rodney, 2013). Insufficient inclusion in decisions regarding nursing-staff mix (when registered nursing staff is reduced) is another example of lack of access to decision-making about resource allocation (Canadian Nurses Association, 2012). Burston and Tuckett (2013) identified individual factors contributing to the experience of MD including character traits such as moral sensitivity; level of

authority, such as the HCPs' position in the organization; and the personal capacity to raise and discuss moral issues. As well, individual values and perceptions of situations such as end-of-life decisions, also contributed to the experience of MD, in that personal values may conflict with unit culture, physicians' decisions, or family preferences (Burston & Tuckett, 2013).

Burston and Tuckett (2013) purpose was to present an overview of the literature on MD to reveal commonalities of factors that contribute to the experience of moral distress. For these authors, the relevance of their synthesis resides in the implications of the effects of MD on nursing and the nursing workforce. For my purposes, the relevance also resides in pointing to the reciprocity that is evident between HCPs and the context, or structures, in which they practice; for example, by examining how site-specific issues such as resources influence care delivery. In focusing on the reciprocity between agents and structure, it has been my intent in this research to move the dialogue on MD beyond implications and toward a more comprehensive and coherent understanding of the concept that is a prerequisite for the future development of effective interventions, as well as prevention of the experience.

In order to examine the reciprocity between health care contexts and moral agents, it is helpful to understand the broader sociopolitical influences on health care decision-making, as well as the historical and global dynamics that contribute to the current context. The overview of literature presented above provided the scaffolding for me to examine the reciprocity between structures

and agents in our current health care climate. To consider the wider sociopolitical context, I began with the federal and provincial context of health care delivery.

Canadian/British Columbia (BC) Health Care Context

The delivery of health care services in Canada is increasingly complex and reflective of concerns in health care delivery that exist at a global level. These concerns include questions about how to deliver high-quality health care in a global context of cost constraints and a shortage of skilled health care professionals. Individual countries' responses to these questions are driven by the sociopolitical culture unique to each country. Indeed, commentators note an overall global trend toward austerity, resulting in overall cuts to health care services that can have a deleterious effect on health at a national population level (Karanikolos et al., 2013; Kentikelenis et al., 2014). The austerity measures implemented to contain health care costs align with the principles of a free market economy, or dimensions of neoliberalism,⁶ as a mode of governance and as a means of informing policy development (Steger & Roy, 2010). Current policy on health care delivery in Canada reflects this global trend and is underpinned by the messages of cost containment and increasing efficiency (Matier, 2012). Some of the commonly cited factors in the rise of health care costs driving such containment and efficiency measures include increasingly expensive technology,

⁶ Steger and Roy (2010) describe neoliberalism as an economic model built on the ideal of a self-regulating market that arose from classical liberalism in the 1980s. They further explain neoliberalism as best thought of as three intertwined manifestations: 1) an ideology; 2) mode of governance; and 3) a policy package.

rising drug costs, an aging population, and increasing chronic illness, a focus on illness rather than prevention, and an overall shortage of skilled health care providers (Canadian Institute for Health Information, 2011; Deloitte Touche Tohmatsu Limited, 2014).

Federally, the Canadian government has responded to these pressures by establishing firm fiscal limits on the amount of money the federal government transfers to the provinces and territories to support health care service delivery (Matier, 2012). There are several concerns with this approach, one of them being that by focusing on the dollar amount that the federal government is transferring to the provinces and territories, the federal government is reducing its role in health care to that of cheque writing (Romanow, Silas, & Lewis). A consequence of this stance may be that the federal government no longer takes the lead in setting national standards for health care delivery and holds the provinces accountable to that standard. This move may have significant implications for equitable access to health care (Browne, 2001; Pauly et al., 2009; Varcoe et al., 2012) in mental health as well as other arenas. A second concern is with establishing firm limits on the Canada Health Transfer (CHT), which creates an overall reduction in the federal portion of money that supports health care service delivery and leaves the provinces and territories endeavouring to deliver health care services with fewer dollars (Romanow, 2002). The significance of the above for my research focus has been the recognition that policy constraints are structuring the practice environment of HCPs and creating the conditions that contribute to HCPs' experience of moral distress. Restructuring health care

delivery to contain costs based on a business model of efficiency has resulted in increased workload for nurses, decreased job satisfaction, increased burnout, increased intention to leave, and increased moral distress (Austin, 2011; Rodney, Kadyschuk, et al., 2013; Rodney & Varcoe, 2012; Shannon & French, 2005).

In British Columbia, where my dissertation research took place, such cost containment has been continuing to escalate. For example, a recent Ministry of Health (MoH) Service Plan called for achieving better value in health care through increasing efficiency (Ministry of Health, 2014b), which has continued to reflect policy underpinned by neoliberal tenets. In order to contain costs and achieve efficiency, the provincial government has transplanted models of efficiency from business, such as the Lean Model,⁷ into the health care system. The recent Service Plan asserts that this restructuring has led to the creation of a “stronger focus on health service planning, policy, analytics, and health service quality assurance. Through this work, we have reduced staffing levels by nearly ten per cent” (Ministry of Health, 2014b, p. 6). From this statement it appears that efficiency has been measured by having fewer people assigned to deliver the same level of service. Focusing on administrative processes and numbers to improve efficiencies is based on the assumption that the quality of the actual care delivered remains unaffected. This has not proven to be the case, as was

⁷ The Lean Model refers to a managerial model that focuses on increasing efficiency and decreasing waste (Kim, Spahlinger, & Billi, 2009). Health care systems in Western countries have applied Lean principles to health care in an effort to constrain cost through creating more efficient processes. D'Andreamatteo et al. (2015) identify that some researchers conceptualize Lean thinking as prioritizing efficient *flow* over efficient use of resources.

evidenced by the Francis Inquiry (2013) from the UK (Hayter, 2013; Musto et al., 2015) to which I now turn.

In 2010, a public inquiry was launched in the UK to investigate the broader health care system that included the Department of Health, the local health authority, and the regulatory bodies to determine how significant breaches in duty could have occurred in the Mid Staffordshire Trust (NHS) Foundation Trust (Francis, 2013b). As a cautionary tale, Francis identified a culture that existed within the Mid Staffordshire Trust that focused on “doing the system’s business—not that of the patients” (p. 4). Efficiency based solely on neoliberal reform has the capacity to interfere with HCPs’ abilities to engage with patients in a way that fosters positive health outcomes, and also hampers their ability to practice in congruence with their ethical standards (Austin, 2012; Mänttari- van der Kuip, 2016). Also, HCPs identify the inability to practice according to their Standards of Practice and Code of Ethics as a source of moral distress (Austin, 2016; Austin et al., 2003; Musto & Schreiber, 2012; Peter & Liaschenko, 2013)

On reviewing the current health care context in Canada and British Columbia as I commenced this study, I found a number of experts pointing to the neoliberal ideology imbued in the structures, culture, and policy that guide health care delivery. An examination of the efforts by the federal and provincial government to constrain health care costs reveals how policy shapes the structures in which HCPs deliver care and also contributes to situations (such as short staffing) that lead to moral distress. Yet, although practice is shaped by policy and culture, HCPs are not passive recipients of these influences. Instead,

HCPs respond in a variety of ways that may uphold or shift the systems that underpin policy and culture (Rodney, Kadyschuk, et al., 2013). For example, Rodney and Varcoe (2012) described acts of *moral resistance*, whereby nurses engaged in a variety of actions that ranged from directly advocating for ethical care to bending the rules in order to meet patients' needs in response to policies that were not in the best interest of the patient.

In responding to the structural elements that shape practice, HCPs demonstrate the reciprocity that exists between structures and agents. My purpose in this study has been to make this interplay explicit so that HCPs can make intentional choices about how they want to interact with the institutional structures that shape their practice. That is, I am pointing to the role of *action* in the experience of moral distress. However, the role of action in the context of moral distress remains ambiguous, and so I investigated this ambiguity when discussing issues regarding conceptual clarity in MD. In order to lay the groundwork for investigating conceptual gaps, it is helpful to review the historical context out of which the concept of MD arose.

Historical Context of Moral Distress and Bioethics

Elements that contributed to the complexity of health care delivery in the 1970s and 1980s included advances in health care technology that could save or extend life, an increase in the variety of HCPs delivering care, social justice issues related to equity and access to health care and other services, an increasingly informed patient population, changes in the regulation of health care

providers, and the increasing domination of health care delivery by a business ethos (Jameton, 1984; Romanow, 2002). These elements, combined with the unique roles and positions nurses occupied in the health care system, gave rise to the experience the Jameton (1984; 1993) identified as moral distress.

Conditions within the hospital structure that contributed to the ethical situations nurses faced included hierarchical structures and increasing responsibility with little access to decision-making processes (Jameton, 1977). It is interesting to note that Jameton identified moral distress and these conditions specific to nursing; however, these conditions continue to exist today, as I have noted above, and are experienced within, and between, many of the health care disciplines.

Although Jameton situated the experience of nurses within the broader health care context, his perspective of what nurses were experiencing was shaped by his own experiences and education in ethics. Leading up to his introduction of moral distress, Jameton (1984) set the stage by situating health care and bioethics within a historical context. He verbalized a rising sense of crisis in the health care system; according to him, “providers sensed basic value conflicts in conducting their work and became concerned about their ability to express their ideals in it” (p. 1). Evident in the description of the crisis that Jameton observed was an inability on the part of the HCPs to reconcile their values with the rapid changes occurring in health care delivery.

In fact, one of the roles of the ethicist is to create a space for the discussion of values within health care (Arras, 2010; Jameton, 1984; Wolpe,

2000). However, a critique of bioethics is the disconnect that exists between ethical theory and the actual practice issues faced by HCPs (Arras, 2010). This critique may have some consequences for the definition of moral distress as I view it, which is as tripartite. By tripartite I mean that the definition can be broken down into three parts: a) making a moral judgment, b) failure to take action, and c) institutional constraints. The lack of conceptual clarity underpinning each part of the definition may partially result from the ambiguous connection between ethical theory and clinical practice.

Indeed, in tracing the rise and evolution of bioethics within health care, critiques of bioethics focus on the utility of applying ethical theory to the situations faced by HCPs (Arras, 2010; Borry, Schotsmans, & Dierickx, 2005; Wolpe, 2000). One of the critiques is related to the disconnection of high-level ethical theory from the situations and contexts of bedside care to direct action (Arras, 2010). High-level ethical theory refers to theories that provide justification for broad ethical concepts, for example, freedom or justice (Arras, 2010; Jameton, 1984). Specific to the critique of bioethics is the concept that high-level ethical theory is not sufficient for examining the messy reality of the immediate context in which specific ethical situations arise, as is the case with the experience of MD (Rodney, Burgess, et al., 2013). For ethical theory to have more practical application and utility at the bedside, an acknowledgement of the structural features of the health care organization is necessary (Arras, 2010; Jameton, 1984). I believe that high-level ethical theory underpins Jameton's definition of moral distress and continues to contribute to a lack of conceptual clarity. For

instance, underpinning the concept of making a moral judgment may include an assumption of the moral agent as an independent and self-determining individual (Rodney, Kadyschuk, et al., 2013; Sherwin, 1998).

In his book *Nursing Practice, the Ethical Issues* (1984), Jameton is clear that he is offering a philosopher's approach to bioethical issues and I propose that his definition of moral distress reflects the strengths of—but is simultaneously confined by—his perspective (Hanna, 2004). In Chapter One, I proposed that the definition of moral distress was predicated on three main assumptions: a) that nurses had made a moral judgment, b) that they did not act on that moral judgment, and c) that inaction was related to institutional constraints. In identifying that nurses made a moral judgment, Jameton identified that “one knows the right thing to do...” (p. 6). Although Jameton acknowledged the broader sociopolitical contexts that shaped nursing action, his explanation of moral reasoning fell within the tradition of moral philosophy. In describing the importance of moral reasoning, Jameton stated that a person's ability to reason and give reasons are central to determining ethical responses (Jameton, 1984). In providing his explanation of moral reasoning, in fact, Jameton was careful to include the importance of intellectual and emotional resources to the process. Nonetheless, I argue that, in taking a solely philosophical approach to moral reasoning and making a moral judgment, Jameton assumes that intellectual and emotional capacities are corralled by our cognitive abilities to aid in making a moral judgment, thereby overlooking the possibility that moral judgments may

also involve different processes when they are made within complex organizational contexts.

Thus, in defining moral distress from the perspective of a philosopher and a bioethicist, Jameton drew on moral theory to explain an embodied experience that was located contextually in the broader sociopolitical and cultural context, as well as in the immediate context of the situation. While this conceptual framing was a landmark achievement at the time, it is my contention that the moral theory Jameton drew on was not fine grained enough to account for the encompassing experience of moral distress described by nurses and other health care providers—including the participants in my study. His theorizing was also not adequate to capture the differences in the experience that occur across health care specialties. Over the past 30 years, particularly the past 10, researchers (Carse, 2013; Deady & McCarthy, 2010; Fourie, 2015; Mack, 2013; Mänttari- van der Kuip, 2016; Ohnishi et al., 2010) have attempted to illuminate the finer details related to local contexts and also capture contributing factors specific to health care disciplines and health care practice contexts. These researchers have, overall, based their studies on Jameton's (1984) original definition. In doing so, they recognize difficulties with the definition and have made necessary, but not yet sufficient, progress in clarifying the concepts that underpin the definition of moral distress (Morley et al., 2017; Musto et al., 2015; Pauly et al., 2012; Thomas & McCullough, 2015).

Moral Distress and Reciprocity

Moral distress is an individual response to situations that result from organizational, cultural, and sociopolitical contexts that frame the situation. Until we understand the processes through which the reciprocity between structures and agents occurs, we will perpetuate the notion that the moral agent acts and thinks independently of the circumstances that shape them. In taking this position, we (at least implicitly) hold the moral agent primarily responsible for the experience of MD. Austin et al.'s (2003; 2005; 2008) work highlights the reciprocity⁸ that is not just at an organizational level, but is also at a societal level, as societal expectations shape the moral obligations of the HCPs. Structural reciprocity extends beyond the level of healthcare organizations. Expectations of HCPs are also shaped at a provincial level through the regulatory bodies that define Standards of Practice, and at a federal level by the professional bodies that establish the professional Codes of Ethics (Austin, 2016; Peter & Liaschenko, 2013).

In order to move toward better conceptual clarity and gain an understanding of the reciprocity that exists between structures and agents, I have organized the material above, and the remainder of this chapter, by separating structural issues that contribute to MD from the impact of the experience on

⁸ Reciprocity in relationships in the health care system are part of the is-ought gap, wherein relationships in health care ought to be reciprocal. Quite often, relationships are not reciprocal, causing power imbalances that contribute to HCP disempowerment.

moral agents. In doing so, my intention is to move beyond the limitations inherent in Jameton's original definition. In the next section I therefore explore what is known about the sociopolitical elements that have contributed to moral distress in mental health care specifically. This review also sets the stage for the analyses of my study findings in Chapter Five.

Moral Distress in Mental Health Care

In Canada, 20% of the population is expected to struggle with mental health issues each year. However, globally, as well as nationally, services for mental health are considered to be inadequate (Mental Health Commission of Canada, 2018; World Health Organization, 2013). As well, many countries, including Canada, face a shortage of HCPs serving mental health populations (Kakuma et al., 2011; Smith & Khanlou, 2013). Canada, along with other industrialized countries, is looking for a way to contain rising health care costs by ensuring an effective and efficient system in health care overall, including mental health care.

Along with cost containment and a shortage of skilled HCPs, the social determinants of health also play a significant role in shaping the discussion on the most cost effective way to deliver mental health care services. The Mental Health Commission (MHC) (2012) developed a multipronged approach to mental health care delivery in Canada that included attention to the social determinants of health. The plan advocates for a recovery approach that includes access to community-based services, peer support, supported housing, education and

employment (Mental Health Commission of Canada, 2012). The development of a national strategy for mental health care took place in a staged process that involved significant consultation with stakeholders across Canada. It also took place against the backdrop of the neoconservative reforms to health care discussed in Chapter One, and as such, it is difficult to know if the federal government will hold the provinces/ territories accountable for implementing the strategies in the MHC⁹.

In BC, the MoH published a mental health plan that was intended to take a broad view of mental health and include health promotion and prevention across and individual's lifespan (Ministry of Health Services & Ministry of Child and Family Development, 2010). While acknowledging the importance of attending to the determinants of health through policy, the language of the mental health plan takes up a similar message of cost constraint seen in the federal document, CHT (Matier, 2012) and the MoH Service Plan (Ministry of Health, 2014b). Focusing on efficiency, the recommendations are concentrated on making more "effective" use of existing services, without questioning the adequacy of current service levels. Although it is difficult to get an exact picture of the adequacy of mental

⁹ The Mental Health Commission of Canada (MHCC) was established in 2007 by Health Canada as an arms length non-profit organization with a specific mandate, for a set period of time--10 years. The mandate included the creation of a national mental health strategy, to reduce stigma, and advancing knowledge exchange in mental health (Mental Health Commission of Canada, 2016). An evaluation of the MHCC acknowledges the effectiveness of the Commission, along with an ongoing need for further efforts to address the mental health needs of the population (Health Canada & Public Health Agency of Canada, 2016)

health services in BC, in Metro Vancouver alone, the Vancouver Police Department has expressed significant concern regarding the increase in police contact with people struggling with mental health issues, and has called for increased services for this population (Thompson, 2010; Vancouver Police Department, 2013; Wilson-Bates, 2008). Such lack of adequate resources necessary to provide care according to professional Standards of Practice has been identified as a structural element that contributes to MD (Austin et al., 2003; Rodney, Kadyschuk, et al., 2013) in HCPs.

Moral Distress and Patient Care in Mental Health

The key to working with patients in mental health is the development of the therapeutic relationship, for it is the medium through which all interventions are delivered (Gardner, 2010; Registered Nurses Association of Ontario, 2002). Research on patient outcomes in mental health supports the notion that the therapeutic relationship contributes improved health outcomes for the patient (Cutcliffe et al., 2015; Hiskey, 2012; Peplau, 1952). As well, researchers conducting studies to explore the therapeutic relationship with nurses working in mental health identify major themes critical to building a therapeutic relationship as entailing trust, power, mutuality, self-revelation, congruence, and authenticity; all in the context of maintaining professional boundaries (Gardner, 2010; Welch, 2005). The themes identified by the participants of these studies suggest that an element that contributes to developing the therapeutic relationship is time. Commentators are noting that the health care system needs to enable processes

that demonstrate the importance of the therapeutic relationship and the HCP needs to maintain a willingness to engage with the patient at the center of their care (Austin et al., 2003; Gardner, 2010; Registered Nurses Association of Ontario, 2002).

For example, in a study by Austin et al. (2003), nurses identified care situations that they found morally distressing. Lack of time emerged as a primary contributor to the experience of moral distress. The lack of time for patient care was attributed to changes in the health care system. Although these changes were not elaborated, the stories told by participants indicated that the changes were a result of attempts to constrain health care costs, which resulted in increased workloads and lack of access to the basic resources necessary to provide care. Participants described how lack of time interfered with developing a therapeutic relationship and being able to provide safe, ethical care. This resulted in nurses feeling disconnected from their patients and each other, and in their failure to treat patients with dignity and respect. The participants in this study described examples of emotional avoidance¹⁰ of the situations that caused moral distress. Avoidance behaviour as a consequence of moral distress was one of the findings by Burston and Tuckett (2012) in their overview of the literature on

¹⁰ De Villers and DeVon (2012) describe nurse avoidance behaviours as more than the absence of a physical presence, stating that it is a conscious effort to “avoid thinking about an event or reminder of an event” (p. 594). Avoidant behaviours include physical and psychological avoidance that includes the absence of physical and verbal contact with the patient, such as, lack of time spent with the patient, limited eye contact, decreased physical proximity, and negative verbal mannerisms.

moral distress and may have consequences for patient outcome, such as failure to rescue.

Failure to rescue (FTR) is a nurse sensitive measure that can be used as part of evaluating the quality of care provided in a hospital (Clarke & Aiken, 2003; Schmid et al., 2007). FTR refers to the “inability to save a patient’s life after the development of a complication” (Schmid et al., 2007, p. 188). As a nurse sensitive outcome, FTR has been tied to staffing ratios, and was initially studied only in surgical units, but research has since extended to medical units, ICUs, and perinatal areas (Clarke & Aiken, 2003; Schmid et al., 2007; Simpson, Lyndon, & Ruhl, 2016). Nurse surveillance underpins the connection between staffing levels and FTR, and includes initial and ongoing assessments of the patient in order to recognize changes in the patient’s health status. Another element of FTR, once a potentially serious complication has been noticed, is that the nurse needs to mobilize hospital resources quickly (Clarke & Aiken, 2003). Along with staffing levels, avoidance of a patient due to the experience of moral distress may also contribute to FTR. Avoidance of patients and FTR are particularly salient in acute care mental health settings where time constraints interfering with the development of the therapeutic relationship have been identified as contributing to the experience of MD. Increasingly, mental health patients are recognized as having significant medical comorbidities leading to a decreased life expectancy (Walker, 2015).

In another study with psychiatric nurses, Ohnishi et al. (2010) examined the relationship between moral distress and burnout in a Japanese context; they

also found that low staffing correlated with moral distress and burnout. More specifically, Ohnishi et al. (2010) also found that the frequency and intensity of moral distress correlated positively with higher levels of cynicism and exhaustion. Interestingly, the authors noted that nurses who took care of more patients reported feeling less exhausted. Taken at face value, this finding appears to contradict earlier findings linking moral distress to low levels of staffing. A potential explanation for this finding is that participants working with more patients were using psychological coping strategies such as moral disengagement in order to protect themselves from any distress they may have felt (Deady & McCarthy, 2010; Rodney, Kadyschuk, et al., 2013). A commonality between both studies was that a lack of external resources led to inadequate care, or patients being treated with a lack of dignity; both situations that created moral distress for many participants.

One of the gaps in our knowledge of moral distress in mental health care is a full understanding of the impact of the experience on the quality of patient care. This includes understanding the influence of avoidance behaviours (Burston & Tuckett, 2013), moral disengagements¹¹ (Rodney, Kadyschuk, et al., 2013), and the impact of moral distress on the formation of the therapeutic relationship in psychiatric settings (Austin et al., 2003). Given that the therapeutic

¹¹ Rodney, Kadyschuk, et al. (2013) draw on Bandura's social cognitive theory to explain, what they describe as "*some nurses' shifting moral identity*" (p.171). Bandura argues that moral disengagement is a mechanism that individuals use to avoid self-condemnation when they engage in behaviours that do not align with their own moral standards (Bandura, 2002). For an in-depth explanation of moral disengagement and how it may apply in healthcare settings, I refer readers to Bandura, 2002, and Rodney, Kadyschuk, et al. (2013).

relationship is foundational to the delivery of interventions in mental health, anything that inhibits the development of that relationship may interfere with fostering positive patient outcomes. Clarifying the relationship between moral distress, burnout, and FTR in mental health care will aid in identifying ways to support HCPs. I examine the relationship between these concepts and the quality of patient care in Chapters Six and Seven.

Summary of External Structures that Shape the Context of Care

I have outlined above some of the historical and current health care structures that shape health care delivery. It is not a coincidence that Jameton identified moral distress in the mid-1980s, at the same time that neoliberal tenets gained political traction and began to influence government policy regarding health care in the early 1970s (Browne, 2001; Steger & Roy, 2010). My purpose in this section has been to situate my study by providing an overview of moral distress and the historical context from which it arose. The issues that have existed historically in health care and that gave rise to a crisis in health care professionals' ability to express their values continue to exist today. Global discourses of fiscal restraint and the application of business models to health care systems have created practice environments that can conflict with core values and Codes of Ethics of HCPs (Austin, 2011). One of the consequences of this values conflict has been the experience of moral distress.

Having outlined some of the structures that shape health care in this section, I examine the moral agent in the context of these structures in the next

section. I do this by reviewing the research on moral distress that has been focused on HCPs' experience of moral distress in an effort to better understand the concept. Initially, I draw on the research across health care specialties; however, in order to better understand how the experience impacts HCPs in mental health, I move on to draw on studies conducted in acute care psychiatric units.

Gaps in Our Knowledge: Reciprocity and The Moral Agent

In this section of the chapter I further examine the role of the HCP as the moral actor in moral distress. Throughout, it is my premise that in order to support HCPs to fulfill their moral obligations to those they care for, we need to understand how reciprocity between structures and agents potentially occurs. There has been growing speculation regarding the potential moral consequences of health care delivery underpinned by a drive for efficiency which has led to ongoing and rapid restructuring of the health care system (Shannon & French, 2005). Some of these consequences include moral disengagement and moral residue¹² (Rodney, Kadyschuk, et al., 2013; Webster & Baylis, 2000). Other negative ramifications linked to moral distress include burnout, compassion fatigue, patient avoidance, and workforce retention issues (De Villers & DeVon,

¹² Moral residue is a term used by Webster and Baylis (2000) to describe the experience where, in the face of moral distress, "we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 218). These moments have a powerful, and lasting, effect on individuals because the moments have threatened, or led to, a betrayal of deeply held values and beliefs. I direct readers to Webster and Baylis (2000) for a comprehensive reading on moral residue.

2012; Maiden, Georges, & Connelly, 2011; Wilkinson, 1987). I argue that these consequences are not solely a result of health care structures and policies impinging on HCPs; instead, they are a result of the interaction between HCPs and these structures. In what follows, I review the literature on moral distress in relation to the impact of the experience on moral agents as well as the responses of HCPs (moral agents) and their subsequent actions. This includes a discussion of the consequences of these actions for health care organizations and for patient care.

Much of the research on moral distress reflects the nursing profession from which it arose; as such, most of the early research studies I draw on are specific to nursing. More recent research has been published, and includes multidisciplinary or interdisciplinary studies in an attempt to establish a more complete understanding of the phenomenon. I draw on a range of literature to try and capture the extent of the consequences and identify the gaps. I will return to some of the literature in Chapter Six as I analyze my own findings.

Relationship between the Code of Ethics and Moral Distress in Mental Health Care

That nursing is a moral endeavour has been well argued elsewhere in the literature (see, for example, Austin 2011, 2012; Corley, 2002; Doane & Varcoe, 2013); however, the influence of a Code of Ethics and Standards of Practice on moral distress is not clear. An example of reciprocity between structures and moral agents is in the development of the moral identity of nurses. Peter and Liaschenko (2013) re-examine moral distress using a feminist lens. In doing so,

they highlight the moral construction of the nursing identity rooted in historical and relational contexts, stating:

The identity of a “nurse” is a social construction. It is generally associated with being a woman, a kind caregiver, an assistant to the physician, and a virtuous healer. These constructions might not reflect the work, gender, or character of many nurses. Yet, this nurse identity is something nurses encounter and perhaps embrace as they begin their education and work. Nurses participate in this construction by the roles they assume and how they describe themselves (p. 339).

The quote above demonstrates the reciprocity that exists between social structures, such as government agencies and professional organizations, and individuals who take up the profession. Professional Codes of Ethics and Standards of Practice are a part of the narrative that shapes socialization into the profession and defines the relationships and responsibilities (Peter & Liaschenko, 2013).

In their research with psychologists, Austin et al. (2005) found that the experience of moral distress was grounded in a sense of professional integrity. The authors identify necessary prerequisites of moral distress as including awareness of ethical issues and accepting moral responsibility. Austin et al. (2005) argue that moral responsibility or obligation are embedded in the role of being a professional and that a threat to professional integrity occurred when psychologists, for example, perceived they were unable to fulfill their moral

obligations. Similarly, Peter and Liaschencko (2013) claim that moral distress may arise due to constraints on moral agency and an inability to live up to socially constructed professional responsibility that is also taken up by individual agents.

Further research with HCPs in mental health care revealed that, in describing their experience of moral distress, HCPs raised concerns about meeting their moral obligations in reference to their professional Standards of Practice and Code of Ethics (Austin, 2011, 2012; Austin et al., 2005; Musto & Schreiber, 2012). These moral obligations are often connected to notions of diminishing suffering, patient advocacy, and safety, which are deeply embedded values in our understanding of what it means to care for the vulnerable other (Austin, 2012; Corley, 2002; Musto & Schreiber, 2012; Peter & Liaschenko, 2013). A professional Code of Ethics arises out of the very discipline that it guides practice for and embodies these same values. As such, it is a guide to the reciprocity that should exist between moral agents and structures.

HCPs are legally bound to practice according to the standards set by their regulatory body (Ministry of Health, 2014a), however, HCPs are also held accountable to societal expectations. For example, a study by Austin et al. (2008) found that psychiatrists experienced moral distress as a result of attempting to balance responsibility to their individual patients according to the Hippocratic principles with the expectation that they will protect society from deviant behaviour. Legal accountability and societal expectations may add to the sense

of moral obligation held by a HCP, and can contribute to the intensity of moral distress when HCPs are unable to balance these tensions.

Multidisciplinary studies indicate that, while moral distress is common across disciplines, the situations that give rise to the experience, along with professional responses, differ (Austin et al., 2008; Dodek et al., 2012; Hamric & Blackhall, 2007). For example, in their research on moral distress in mental health, Austin et al. (2003; 2005; 2008) found that nurses communicated that lack of time to develop a therapeutic relationship with their patient contributed to experiencing moral distress (Austin et al., 2003). Psychiatrists identified that trying to balance ethical responsibility to their patient with their obligation to protect society contributed to moral distress (Austin et al., 2008). Appreciating these distinctions may shed light on professional differences in understandings of moral obligations. The importance of the role of a professional Code of Ethics and practice standards may apply across all areas of health care delivery; however, it is also necessary to understand how societal expectations specific to the different areas influence moral distress.

It is important to note that research on moral distress in health care has been confined to regulated professions. Conducting research with unregulated HCPs may actually help delineate the role of Standards of Practice, which is one of the structural elements that shape moral distress. As well, conducting research on moral distress with patients and family would provide depth to our understanding of the concept. Nevertheless, for my purposes, I confined this study to regulated health care professionals.

An Evolving Definition

Making a moral judgment. Wilkinson (1987) was the first researcher to specifically examine the concept of moral distress after Jameton established it in the literature. In developing her study, Wilkinson drew on key areas of literature that foreshadowed the struggles that exist with the definition that exist today. As I noted above, Jameton's definition of moral distress was likely underpinned by theoretical concepts rooted in moral philosophy, Wilkinson was also the first researcher to adjust the definition to reflect the participants' actual experience based on inductive research rather than deductive reasoning. Wilkinson (1987) 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 behaviour indicated by that decision" (p.16). Since this time, researchers have continued to modify the definition in order to account for some of the ambiguity that emerged in their research (See the table in Appendix A for an overview of the evolution of the definition).

In incorporating the affective experience of participants, Wilkinson moved away from theoretical moral decision-making frameworks rooted in cognition and toward contemporary views of moral development. One prominent theory of moral reasoning was based on the work of Lawrence Kohlberg, who presented a model of moral development based on a staged progression (Kohlberg, 2008/1963). In Kohlberg's model, based on an ethic of justice, the highest stage of moral development reflected moral decision-making based on the application of moral principles to determine the correct action (Kohlberg, 2008/1963).

Participants demonstrated their moral reasoning processes by working through hypothetical situations posed by Kohlberg and his research team.

Carol Gilligan, a student of Kohlberg and others later critiqued his work as being explicitly male gendered (biased), as well as influenced by the sociopolitical context of the day (Flanagan, 1982; Gilligan, 1982; Walker, 2004). Gilligan presented her own, equally gendered, model of moral development grounded in a contextual and relational approach to moral reasoning based on an ethic of care (Gilligan, 1982). The next decade saw a debate polarized along the line of gender that did little to advance our understanding of how moral reasoning could be moved to moral action. It is against this backdrop that Wilkinson situated the moral reasoning of HCPs within organizational structural processes (Wilkinson, 1987); see also Rodney, 1997.

In the mid-1990s, another shift began in the field of moral psychology that tapped into research findings from neuroscience. Although still very much a developing field, neuroscientists are beginning to shed light on the processes that take place in the brain as participants engage in moral reasoning (Damasio, 2007; Decety, Michalska, & Kinzler, 2011; Greene, 2014; Moll & de Oliveira-Souza, 2007; Moll, de Oliveira-Souza, & Eslinger, 2003; Narvaez, 2014). It has become apparent that moral decision-making is a complex process that involves an interplay between morality, brain structures, and human experiences, as well as “environmental influences, such as early experiences, formal education, and ordinary interpersonal transactions” (Moll et al., 2003, p. 304), that shape the structures of the brain used in moral reasoning.

My point here is that our understanding of moral reasoning at this moment in time is far more nuanced than when Jameton introduced the concept of moral distress. In order to understand how HCPs make moral judgments and turn these judgments into moral action in an organizational context, we need to incorporate knowledge from neuroscience and moral development. Understanding the process of moral reasoning could help researchers develop interventions that support HCPs as they navigate organizational barriers to moral action.

The concept of constraints. Wilkinson also showed that constraints could be actual or perceived, and could be external or internal to the participant. Austin et al. (2005) took this speculation further and connected the lack of moral action to an internal failure that may have lasting consequences for the individual. In locating constraints solely within the realm of the organization, Jameton inadvertently perpetuated the belief that nurses were powerless to act in the face of organizational and hierarchical authority. This, in fact, was not true; something that he acknowledged when he further refined his definition to include initial and reactive moral distress (Jameton, 1993). He encouraged nurses to take on the “*the perspective of the responsible actor*” (p. 547; original italics), to help delineate the extent of professional responsibility in an organizational setting. Taking up the role of a responsible actor instead of the perspective of a victim powerless to create change, is an example of how internal constraints may either inhibit or support a person to take action. In this way, our understanding of constraints moves away from determining the location and toward examining how the interaction between the environment and HCP generates a particular

response from the agent. This view of constraints may ultimately provide a more accurate picture of the kind of interventions that will help support HCPs as they enact their moral agency. Nonetheless, it remains understudied, and has therefore been an area of focus for my dissertation research, and is reflected in my findings in Chapters Five, Six, and Seven.

The role of action. Central to the experience of moral distress is the role of action or inaction; the accompanying assumption is that taking action will alleviate the experience of moral distress. This has not proven to be the case, as researchers in moral distress clearly identified situations in which HCPs took action either directly or indirectly without experiencing relief from moral distress. In several studies, researchers recount instances of participants taking action in morally distressing situations, only to discover that the repercussions of their action caused further distress (Austin et al., 2003; Musto, 2010). For example, some participants have spoken up regarding ethical concerns only to find themselves ostracized from the health care team (Musto & Schreiber, 2012).

Another problem with the idea of taking action in moral distress is the question of what counts as action. Importantly, Wilkinson was also the first to speculate about, and develop, a substantive theory of moral distress that linked the long-term consequences of the experience on nurses to the quality of patient care (Wilkinson, 1987) they were able to provide. The substantive theory began to point to the reciprocity that existed between structures and agents as it tracked nurses' responses and actions from the inception of the experience through coping strategies to the resulting consequences on the nurse and patient care.

Wilkinson (1987) acknowledged that the impact of effective coping strategies on nurses was that they maintained wholeness and engaged in compensating behaviours with their patients. In contrast, ineffective coping resulted in nurses avoiding their patients, feeling powerless and overwhelmed, and leading the nurse to leave the unit or the profession (Wilkinson, 1987)(Wilkinson, 1987)(Wilkinson, 1987)(Wilkinson, 1987)(Wilkinson, 1987)

Wilkinson attempted to demonstrate the dynamic nature of the process as the nurse accessed coping strategies to rectify a situation. Thus, Wilkinson was indicating that moral distress is not always an immediate reaction to a specific situation but may also occur over time as the HCP reflects on the situation or an ongoing practice (Musto, 2010; Musto & Schreiber, 2012). The idea of frequency of exposure to morally distressing events has been correlated to increasing intensity of the experience and moral residue (Epstein & Hamric, 2009). The line between coping strategies, such as avoidance when the situation is ongoing, and actions to resolve the situation, is ambiguous.

Although Wilkinson (1987) did not offer a critique of Jameton's definition, she pointed to moral theorists who gave weight to the affective dimensions of moral reasoning and who opened up the space between moral reasoning and moral action for questioning. It is only in the past ten years that significant critiques of the definition have arisen (for example, see Hanna, 2004; Johnstone & Hutchinson, 2013; McCarthy & Deady, 2008; Morley, Ives, Bradbury-Jones & Irvine, 2017; Musto, Rodney & Vanderheide 2013; and Varcoe et al., 2012 for a summary of the critiques). Researchers have identified significant gaps within the

definition and have subsequently made slight adjustments; nonetheless, the early definition remains widely used as the foundation for research seeking to further our understanding of the concept (see, for example, Carse, 2013; Hamaideh, 2014; Mason et al., 2014).

Until recently, one of the few measurement tools available to assess the extent of moral distress was the Moral Distress Scale (MDS) (Hamric, 2012). The MDS was based on Jameton's conceptualization of moral distress and has been widely used as a measurement tool in research studies that could directly measure the construct of moral distress (Hamaideh, 2014; Karanikola et al., 2014; Ohnishi et al., 2010; Zuzelo, 2007). While empirical measurement of the concept has been an important potential means of influencing practice and policy, retaining the original definition has not moved our understanding forward in any significant way. My intent in examining moral agency in this dissertation was to bring further clarity to the role of action in the concept of moral distress, and explore the elements that influenced constraints on moral agency in ethically challenging situations. It has been my conviction that the findings from this study could then be used to inform the development of a measurement tool that accurately reflected the experience of moral distress.

Impact of Moral Distress on HCPs

Notwithstanding the evolving nature of our understanding of the definition of moral distress, there is general agreement among researchers that moral distress has a significant impact on HCPs, and consequently on patient care, as

well as health care organizations (De Villers & DeVon, 2012; Pauly et al., 2009). Wilkinson conducted in-depth interviews with 26 participants from the nursing profession who self-identified as having experienced moral distress. Her participants identified significant impacts on their physical, psychological and emotional health that included loss of self-worth, an effect on personal relationships, psychological effects, nightmares, palpitations, headaches and diarrhea (Wilkinson, 1987); subsequent research has supported, and added to, these findings (Austin et al., 2005; Corley, 2002; Elpern, Covert, & Kleinpell, 2005). However, moral distress need not have a negative outcome for HCPs, as wrestling with values and value conflicts may help clarify the moral boundaries of care (Hanna, 2004; Webster & Baylis, 2000).

Integral to fostering processes that support the potential positive benefits of the experience is the understanding of the role of reciprocity between the health care environment and HCPs in the choice of coping strategies to work through moral distress. As HCPs try to manage these negative and uncomfortable affective states, they engage a variety of coping strategies with varying levels of success (Austin et al., 2005; Deady & McCarthy, 2010; Musto & Schreiber, 2012; Wilkinson, 1987). Coping strategies for moral distress identified in the literature include, but are not limited to, talking to a supervisor and/ peers; self-reflection; reacting by minimizing, trivializing or rationalizing the situation; and working part-time (Deady & McCarthy, 2010; Musto & Schreiber, 2012; Webster & Baylis, 2000; Zuzelo, 2007). The choice and success of these strategies are also reflective of the interplay between the internal structures of

the participant and the external environment. For example, when HCPs chose to bring ethical issues forward to their supervisors, their belief in the effectiveness of this strategy was based on the individual's past experience of bringing up similar issues with their supervisor (Musto & Schreiber, 2012).

Several researchers discuss the importance of health care organizations being receptive to, and providing the space and time for, discussion (Huffman & Rittenmeyer, 2012; Mitton et al., 2010; Rodney, Buckley, et al., 2013; Ulrich, Hamric, & Grady, 2010). Understanding how the external environment influences individual choices regarding coping strategies, as well as how individual internal structures allow some individuals to pursue strategies that support an ethical environment, can ultimately provide a foundation for advancing interventions. On the basis of my analysis of my dissertation findings, in Chapter Six, I discuss organizational resources and processes that influenced participants' choice of strategies as they navigated ethical challenges. In Chapter Seven, I put forward suggestions for how the organizations can support the enactment of moral agency.

If the practitioner is unable to resolve the experience of moral distress, the consequences may include moral residue (Webster & Baylis, 2000), moral disengagement (Rodney, Kadyschuk, et al., 2013), and/or a decision to leave the area of work or even the profession (Dodek et al., 2012; Hart, 2005). Moral residue refers to the lasting impact that resides within an individual following an experience where he or she was seriously morally compromised (Webster & Baylis, 2000). The sequelae of moral residue can be that it helps the individual

clarify values for when future situations arise. Alternatively, the individual may become disconnected from his or her values, becoming a “moral chameleon” (Webster & Baylis, 2000, p. 224). Both outcomes have consequences for the organizations in which the moral agents work. In the first case, the person can help the organization maintain a high-level of moral commitment to patient care. In the second case, the person becomes desensitized to wrongdoing or constantly shifts his or her values to align with the situation at hand, which may lead to errors in judgment with regard to clinical care.

Exploring related concepts. Other possible consequences for HCPs that have been linked to moral distress are burnout and compassion fatigue. Burnout is a recognized syndrome characterized by exhaustion and cynicism (Maslach, Schaufeli, & Leiter, 2001; Robinson, Clements, & Land, 2003), and compassion fatigue describes an inability to care for others related to emotional exhaustion as a result of secondary exposure to high stress situations (Maiden et al., 2011). Both of these phenomena have been linked to moral distress and have similar consequences with regard to patient care, including avoidance (Maiden et al., 2011; Robinson et al., 2003). Maiden et al. (2011) set out to examine the relationship between compassion fatigue, moral distress, perceptions about medication errors (as an indicator of unsafe practice and work environment) and nurse characteristics. They found a positive correlation between compassion fatigue and moral distress. They also identified environmental issues such as blame and punitive administrative responses that led to strong negative effects—for example horror, devastation, and fear—that contributed to a lack of reporting

of medication errors. In making this connection, the authors highlight the interplay that exists between external environmental structures and the internal environment of the HCP.

As I stated at the beginning of this section, there is general agreement that the experience of moral distress can have a harmful effect on HCPs. Likewise, researchers have also pointed out the negative impact on moral distress on the organization related to turnover, retention, productivity of employees, and, significantly, on patient care (Mitton et al., 2010).

Relationship Between Moral Distress and Patient Care

The purpose of Wilkinson's (1987) study was to develop a substantive theory about the relationship between moral aspects of nursing practice and the quality of care. For her study, Wilkinson assumed that, as nursing was a moral profession, acting in a way that contradicted the values of nursing would have consequences that impact patient care. Participants articulated both positive and negative strategies for managing the situations that led to moral distress. Successful coping strategies prompted participants to compensate their patients, providing extra emotional support and being attentive to their physical needs, to make up for the situation. Instances of unsuccessful coping led participants to avoid the patient who was a part of the situation that created moral distress (Wilkinson, 1987). The concept of avoidance is significant to the quality of patient care and is connected to moral distress both directly and indirectly. As is seen in Wilkinson's study, and supported in subsequent research, HCPs acknowledge using avoidance of the patient or situation that led to moral distress as a

protective mechanism against further distress (De Villers & DeVon, 2012; Gutierrez, 2005; Wilkinson, 1987, 1989).

Avoidance can take different forms, including asking not to take care of a specific patient, distancing from the patient, not engaging with the family, or even avoiding work altogether (Gutierrez, 2005; Musto & Schreiber, 2012). The study by De Villers and DeVon (2012) demonstrated a correlation between the experience of moral distress and avoidance in both critical-care and noncritical-care nurses. FTR is based on the notion of a preventable death in health care (Clarke & Aiken, 2003), and was initially used as a measure of hospital performance that measured HCPs' response to patients following the development of complications postsurgery (Schmid et al., 2007; Trudeau, Clarke, & Aiken, 2003). As a measure of performance levels in hospitals, the concept had been linked to staffing levels, education level of nurses, and skill-mix; however, understanding how ethical elements may contribute to FTR has been overlooked. Central to FTR is not recognizing the deterioration in the status of a patient and instituting the appropriate interventions in a timely manner.

Interestingly, in several studies on moral distress, nurses do not identify a change in the quality of care even though they describe behaviours of avoidance (Gutierrez, 2005; Wilkinson, 1987). This raises the concern of whether or not nurses struggling with moral distress recognize if, or when, the quality of the care he or she provides is not adequate to meet the needs of the patient. The causal relationships between the quality of patient care and levels of moral distress have not been fully explored. Yet, there is some indication that when HCPs morally

disengage, the quality of healthcare delivery deteriorates (Rodney, Kadyschuk et al. 2013; Rodney, Buckley et al. 2013).

A further consideration for my study on moral distress has been the relationship between avoidance and FTR in mental health. In research on moral distress specific to mental health, nurses described coping strategies that included avoidance and distancing themselves from the source of the problem (Deady & McCarthy, 2010; Musto, 2010). Avoiding a difficult patient due to moral distress may result in missing the deterioration of the status of the patient leading to FTR. The main question in a mental health setting, then, is what are the consequences of missing the deterioration of a patient's status? The care of mental health patients in acute care settings has become more complex due to higher acuity and increased comorbidity related to diabetes, dyslipidemia, hypertension, and obesity (American Psychiatric Nurses Association, 2012). I was unable to find any literature on FTR in the context of mental health settings. Given that there is also limited research on moral distress in mental health, further studies such as the one I have undertaken in this dissertation, are necessary in order to understand the potential consequences of moral distress for HCPs and the quality of patient care.

Moral Distress Research in Mental Health

As our knowledge of moral distress has increased over the past 30 years, and increasingly, there have been calls to move toward effective interventions (American Association of Critical-Care Nurses, 2008; Bell & Breslin, 2008;

Hamric, 2012; Pendry, 2007; Rodney, Kadyschuk, et al., 2013). This call for interventions has recently led three ethics journals¹³ to devote full issues to the topic (Musto et al., 2015). Nevertheless, despite the growing interest in moral distress, few studies have been conducted in mental health care (Austin et al., 2003; Deady & McCarthy, 2010; Nuttgens & Chang, 2013; Ohnishi et al., 2010).

The studies that have been conducted in mental health care reveal similar findings of moral distress in relation to emotional, physiological, and psychological consequences. As well, research participants in mental health care express similar strategies for managing the experience, including intentions to leave the health care unit or the profession (Musto, 2010). Having said this, as can be seen in the literature reviewed above, there remain significant gaps in our understanding of the impacts of moral distress. This includes gaps in knowledge in mental health about the situations that contribute to the experience, such as involuntary treatment, restraint and coercion, and how moral distress influences patient care (Austin et al., 2008; Deady & McCarthy, 2010; Musto & Schreiber, 2012). Also unknown is the impact of moral distress on patient safety (Austin et al., 2008; Musto & Schreiber, 2012), and the interaction between moral distress, avoidance, compassion fatigue, empathy, vicarious trauma, and burnout of health care providers (Moffic, 2014; Robinson et al., 2003; Severinsson & Hummelvoll, 2001).

¹³ Namely: HEC Forum, Journal of Bioethical Inquiry, and Nursing Ethics

Summary of Conceptual Gaps

Having reviewed the literature regarding moral agents in this section, I have elaborated on the gaps in our conceptualization of moral distress. I began with the first research on moral distress by Wilkinson, as I believe this study foreshadowed the difficulties subsequent researchers would have, and continue to have, with the concept of moral distress. The gaps in our understanding include:

- Ambiguity with regard to Jameton's original definition, which is related to the consequence of rooting the definition in moral philosophy
- Our incomplete understanding of moving moral reasoning to moral action
- Lack of insight regarding the role of action in ameliorating the experience
- Our difficulty with teasing out moral distress from related concepts such as burnout and compassion fatigue
- Limited understanding of the impact of moral distress on patient care¹⁴

In the next section of this chapter, I review some of the interventions that have been trialed in an effort to support HCPs to work through experiences of moral distress. In so doing, I continue setting the stage for the rationale for, as well as the implications of, my own study.

How Reciprocity May Shape Structures and Agents

In this section of the chapter I present my perspective on how I view reciprocity between structure and agents (see Appendix B). The diagram in

¹⁴ See also Musto and Rodney (2016), Rodney, Buckley, et al. (2013); Rodney, Kadyschuk, et al. (2013)

Appendix B is a representation of my thinking about what the reciprocity between structure and agent might look like and a depiction of the potential for iterative change in both. I also assume that HCPs and organizational structures are open systems that have the capacity to adapt and change. As I explore neuroplasticity, I speculate that it is potentially the process that makes change possible as a result of the interplay between structures and agents. Below, I briefly outline the literature from embodiment, neuroscience, and attachment that has informed my thinking about the mutual relationship that exists between health care structures and HCPs.

Embodiment. In order to construct an embodied understanding of the interaction between structure and agency, I drew on research from neuroscience that calls for an integrated perspective on human behaviour grounded in evolutionary biology and neurobiology (Damasio, 2010; Moll et al., 2003). An evolutionary perspective is based on understanding the brain as consisting of three parts: the primitive brain that evolved first; the mid-brain or limbic region that plays a role in mediating emotion, motivation, attachment, and memory; and the neocortex, the last part of the brain to fully develop and also the portion that is involved with complex information processes such as perception, thinking and reasoning (Damasio, 1994, 1999; Siegel, 2012). Research by neuroscientist Joseph LeDoux on the experience of fear shows how rapidly the lower structures in the brain respond to a threat and initiate a bodily response to the perceived threat *before* this information is sent to the neocortex (LeDoux, 2003; LeDoux, 1993).

I argued in Chapter One that, at its root, moral distress is a boundary violation, and therefore may be perceived by the body as a threat to survival (Musto et al., 2015). What this means in the context of moral distress as an embodied experience is that when moral boundary violations are perceived as a threat to survival, the fight or flight systems are activated *before* cognition kicks in (Shay, 2012). Taking this approach to examining moral distress, I am moving away from a merely cognitive understanding of what occurs when our values are violated and toward integrating the whole body response that has been described by participants in research, including this dissertation. In doing so, I hope to further an understanding of moral distress that appreciates moral agents as embodied beings; beings who use their body, brain, and mind¹⁵ to determine and carry out moral actions. Thus, I view moral agency as an embodied process whereby individuals are in constant relationship with their environment, making decisions about moral action based on what is possible given the circumstances specific to that moment in time. I outline how I understand the dynamic connection between embodied agents and structures in the following paragraphs.

¹⁵ For my purposes, in this dissertation I use Siegel's (2012) definition of the "mind," which is, "A core aspect of the mind is an embodied and relational process that regulated the flow of energy and information" (p.2). Siegel uses this description as a starting point to discuss the connection between the mind and the brain. Siegel points out that "energy and information flow is what is shared among people within a culture, and this flow is what is measured within a brain scanner" (p.3). This definition of mind can account for my understanding of how we take in information in an embodied way and how that information is shaped by a relational context that is socially, politically, culturally, and historically situated.

Embodiment and integration. As our knowledge of the body and bodily systems has grown, we have come to recognize how intimately connected our body is to the environment; so connected, in fact, that we often don't notice that connection until, for some reason such as a bodily crisis, the connection is interrupted (Schenck, 1986). An example of an interrupted connection, or disembodiment, from mental health care is the experience of dissociation whereby an individual becomes disconnected from his or her bodily experience (Ray, 2006). Dissociation occurs in times of extreme stress or in the aftermath of trauma (e.g. car accident, threatened physical attack etc.) (American Psychiatric Association, 2013). Schenck (1986) points out that the body is in constant communion with the world, and as such, it is the way in which we come to know the world.

The same idea is carried through in the literature on structure and agency in the concept of embodied structures. Embodied structures refer to the habits and skills inscribed on the human body by institutional and relational structures that allow these structures to be reproduced or transformed (Elder- Vass, 2008). From this standpoint, much of what is inscribed upon our bodies resides in our unconsciousness, outside of our awareness, yet directs our behaviour, and underpins our values and perceptions. For example, in mental health, transference is the act of transferring experiences from one interpersonal relationship to another (Jones, 2004). Although this is an unconscious process and occurs outside our awareness, the result is that a past relationship influences a person's behaviour in a present relationship (Jones, 2004). The

implication for moral distress is that past experiences with ethical challenges will likely influence a HCP's subsequent responses to ethical challenges.

In attempting to gain a greater depth of understanding of the experience, we must first recognize that it begins as a *felt* (sensory) experience in the body. Within the idea of embodiment, there sits the notion of integration, or a lack of separation between experiencing, thinking, and doing. Historically, the idea of integration does not fit easily with researchers who hold the perspective of scientific dualism that seeks to separate the objective from the subjective, and the emotional from the rational, in order to discover scientific truth (Benner, 2000; Lawler, 1997). However, findings from researchers in neurobiology are beginning to point to the need to understand human behaviour and human decision-making from the perspective of integration between the mind, body, and brain, as well as influences from our environment (Damasio, 1994; Schore, October 2005; Siegel, 2010, 2012). This perspective of integration, coupled with recognition of reciprocity between structure and the agent, has significance for our understanding of moral distress and moral agency.

Recognizing moral distress as an integrated and embodied experience opens up new spaces to develop interventions. One example of developing interventions within a framework of understanding moral distress as an integrated experience comes from Rushton, Kaszniak, and Halifax (2013b). These researchers have developed a framework for understanding moral distress that incorporates emotional attunement, cognitive attunement, and personal experience, with responses that result from perceived violations of professional

ethical responsibility. The framework highlights potential areas for intervention that may help ameliorate the experience of moral distress (Rushton, Kaszniak, & Halifax, 2013a). In developing a framework that can accommodate an embodied response to moral distress, Rushton, Kaszniak and Halifax reached across the disciplines of nursing ethics, social psychology, and neuroscience.

Neuroplasticity. Researchers in neuroscience have added to our knowledge base in two areas that are pertinent to my study of the reciprocity between agents and structures: broadening our knowledge of structural and functional brain growth, and providing insight into how moral thinking may take place in the brain. Neuroplasticity refers to an adaptive response by which neurons seek out and form new pathways (Doige, 2007; Edelman, 1993). It is dependent upon a confluence between elements within an individual, such as genetics and environmental factors. For example, research in neuroscience and mental health supports the contention that mental illness is a result of a combination of environmental factors, genetics, and neuroplastic changes (Kays, Hurley, & Taber, 2012; Pittenger & Duman, 2008). Structural changes will be seen in the brain of an individual who practices a skill (e.g. meditation, music, or sports) on a daily basis (Doige, 2007). Pruning, or neural depletion, is also detected in the brain when neural pathways are no longer used or not used as regularly (Underwood, 2006). Pruning is also observed in people who experience chronic stress (Davidson & McEwen, 2012). Another important feature of neuroplasticity is that the brain is adaptive, depending on the environment. For example, although neurons appear to shrivel when a person experiences

ongoing stress, the neuropathways do not actually die, and the changes appear to be reversible (Davidson & McEwen, 2012). This potentially means that a health care environment has the capacity to enhance or inhibit neural growth and that the neural growth is amenable to change depending on the factors influencing that environment (Beumer, 2008; Musto et al., 2015).

Morality and neuroscience. Researchers in neuroscience have also moved the debates in moral psychology beyond the polarized gender debates regarding Kohlberg and Gilligan by demonstrating that moral reasoning is complex and draws on a variety of areas in the brain (Damasio, 1994; Lapsley & Carlo, 2014; Moll & de Oliveira-Souza, 2007; Moll et al., 2003). Morals are found to be deeply embedded in the brain and draw on the same circuitry as emotions (Decety et al., 2011; Moll et al., 2003), indicating that values are emotionally held and that it is not possible to separate *thinking* about values from an emotional response. Indeed, researchers examining individuals with particular brain lesions found that effective moral reasoning may require the incorporation of prosocial moral emotions (Damasio, 1994; Moll & de Oliveira-Souza, 2007). These findings also indicate that moral judgment begins outside of our conscious awareness and direct moral action without intentional reflection. This has led researchers to debate the connection between moral reasoning and moral action¹⁶ (Greene, 2003; Greene & Haidt, 2002; Kihlstrom, 2013). These findings have implications for our understanding of moral agency and moral distress. In particular, these

¹⁶ For an overview of the debate regarding moral action please consult John Templeton Foundation, *Does moral action depend on reasoning* (2010), at <http://www.templeton.org/reason/>

findings may point to the importance of interventions that focus on discussion, such as the one described by Wocial et al. (2017), to create an open space for bringing moral intuitions and judgments into conscious awareness so HCPs can take thoughtful and intentional moral actions. I noted at the beginning of this section that emotions and moral appear to be intertwined. As such, central to being able to discuss ethical situations is the ability to regulate our emotional states, or to self-regulate. The capacity for self-regulation begins in infancy in the parent-child relationship, however, continues to be shaped by interpersonal relationships and contexts across throughout life (Narvaez, 2014; Schore, 2005; Siegel, 2012)

Attachment. Siegel (2012) defines attachment as “an inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant caregiving figures” (p. 91). Although attachment forms in infancy around primary care givers, these early relationships can have a significant effect on subsequent relationships and an individual’s capacity to self-regulate across the life span (Schore, 2002, 2005; Siegel, 2012). Researchers in attachment have linked the quality of early attachment relationships to subsequent vulnerability to mental health problems (Schore, 2005; Siegel, 2012). As well, secure attachment is perceived to be protective against the physiological and emotional consequences of stress (Gunnar, 1998; Maté, 2003). Conversely, brain scans comparing brain structures of securely attached individuals against individuals raised under traumatic or neglectful circumstances reveal marked differences in brain structure and volume

(Perry, 2004). Environmental issues, such as neglect or trauma, disrupt or impair structural development in the brain (Gunnar, 1998; Perry, 2004, 2009). Thus, early (external¹⁷) attachment experiences shape the (internal) brain structures of an individual, setting a template for the person's capacity to manage adversity in later life.

As I noted above, although attachment begins in infancy, it continues across the life span, albeit in a different form, and in times of stress, many adults engage in behaviours that reflect a need for comfort, support, or advice, and seek out someone viewed as an attachment figure (Siegel, 2012). For adults, this may include close friends, family members, or mentors. For example, in my earlier research with mental health nurses working with adolescents, after experiencing a distressing situation, several nurses described seeking out colleagues they viewed as mentors for support or advice on how to manage the situation the next time it occurred (Musto & Schreiber, 2012).

The above material has informed my study in several ways. First, the process of forming attachment relationships and results of these attachment relationships are examples of how external structures, relationships, and processes, have a clear and direct influence on the internal structures of an individual. The processes that are shaped in the person through the attachment relationship across their lifespan (for example the regulation of internal states,

¹⁷ In Chapter Three, I present a case for extending the definition of structure to encompass both—the internal biological, physiological, psychological, and emotional structures and processes of the person, as well as structures (material and non-material) in the external environment.

social engagement, and the capacity for self-reflection) will also have an impact on the environments they inhabit. In this research, the environment is the complex and stressful health care setting in which they work. As well, the fact that HCPs have a propensity to seek out colleagues and mentors when faced with a morally distressing situation, provides a potential avenue for intervention.

Review of Interventions in Moral Distress

Some individual strategies identified to ameliorate moral distress include education in ethics and moving ethics to action, improving communication, seeking support from ethics committees and/or chaplaincy, developing critical self-reflective skills, and building personal resiliency (Burston & Tuckett, 2013; Rodney, Kadyschuk, et al., 2013). Other strategies directed at a more collaborative approach to alleviating moral distress include, but are not limited to, fostering inter-professional dialogue to facilitate a greater understanding of the perspectives of other disciplines, as well as interdisciplinary ethics education and ethics rounds (Burston & Tuckett, 2013; Rodney, Buckley, et al., 2013).

Notwithstanding the abundance of research in moral distress, in particular over the past decade, I have been able to locate only four empirical studies actually focused on measuring the effectiveness of interventions (Beumer, 2008; Kalvemark Sporrang et al., 2007; Rogers, Babgi, & Gomez, 2008; Wocial et al., 2017). This may be a reflection of the current state of the concept of moral distress, along with difficulties in devising effective ways of measuring such a complex phenomenon. Three of the studies were education based, while one

study focused on fostering open discussion in ethically challenging situations (Wocial et al., 2017). In the studies where researchers focused on educational interventions, only two studies focused on developing ethical competency and the third provided education about moral distress and strategies for coping.

One study by Rogers et al. (2008) offered monthly, one-hour educational sessions over a six-month period. Topics for the educational sessions consisted of: pain management, symptom management, ethical/legal issues, communication/culture, spiritual/anxiety issues at end-of-life, and prevention of compassion fatigue. The topics resulted as follow-up on problematic clinical, ethical, and legal issues surrounding neonatal care (Rogers et al., 2008). This intervention was developed in response to moral distress experienced by HCPs on a neonatal intensive care unit (NICU), with the main goal of improving neonatal and pediatric end-of-life care, and potentially resolving some of the morally distressing issues. Pre and post-measures demonstrated that the participants found the educational intervention helpful overall in increasing their comfort levels in working with neonatal end-of-life issues.

Interestingly, although Rogers et al. (2008) recommend educational intervention for NICU health care staff, they state that “The most important piece to take into consideration is providing the NICU staff with all the support they need” (p. 64). Thus, they further recommend ongoing support, debriefing with outside experts, multidisciplinary team meetings, and sessions to discuss lessons learned following the death of an infant. These recommendations make it difficult to determine if the education provided was solely responsible for the

increased level of comfort expressed by the participants, or if the opportunity to spend time discussing the issues confronting the nurses related to end-of-life care contributed to the overall benefit of the intervention.

Kalvemark Sporrang et al. (2007) offered a multidisciplinary intervention directed toward developing ethical competence. Participants were drawn from two areas: pharmacies and clinical settings. The intervention consisted of three ethics lectures and three ethics rounds. The ethics lectures included information regarding ethical theory as a tool for decision-making, theories of human dignity, and topics pertaining to medical ethics such as prioritization in health care practice (Kalvemark Sporrang et al., 2007). The ethics rounds were multidisciplinary and incorporated ethical discussions of situations from clinical practice. The level of moral distress was measured pre and post intervention; however, the participants demonstrated no statistical benefit from the intervention. Having said this, participants did express appreciation for the opportunity to discuss morally laden problems they confronted in everyday clinical life. The authors offered some potential explanations for this finding, including that the intervention was not sufficient to impact the outcome variables and the intervention actually increased awareness and understanding of the underlying moral issues. A third reason offered by the authors was that the lower attendance rate of the clinical staff was due to lack of time and work tasks that could not be handed over to anyone else (Kalvemark Sporrang et al., 2007). This sampling of some of the potential explanations for a lack of statistical change may also be an indication that interventions need to take into account the needs

of the audience, and ensure that they are directed toward these needs (Hamric, 2012).

In his study, Beumer (2008) offered a workshop that provided education targeted specifically to moral distress. Nurses had the opportunity to identify situations that created distress and discuss the impact these situations had on them. They were provided with information about moral distress, along with strategies to help manage it. Each participant was encouraged to develop a plan to reduce stress and improve his or her individual well-being. The nurse manager joined the group to discuss unit-specific strategies to minimize or cope with moral distress (Beumer, 2008). Pre and post measurements were taken, along with measurement from a control group that had not been involved with the intervention. Beumer (2008) found that participants experienced an overall decrease in their experience of moral distress, and importantly, an improved involvement with the patient and an improvement in the overall work environment.

While it would be simple to declare the educational component in Beumer (2008) study effective, it would also be premature. Beumer's intervention captures the complexity of understanding moral distress as an embodied experience that is in relation to the health care environment. Although Beumer's intervention study was educationally based, it also included participation from the nurse manager and an opportunity to problem-solve unit issues collaboratively. Further, there was an opportunity for individual voices of bedside nurses to be heard by management, and as such, directly confronted several elements that

contribute to moral distress. Conversely, the participation of the nurse manager may have also confounded Beumer's findings; for example, did the staff feel comfortable bringing up critical ethical concerns with the manager in the room? Surprisingly, given the positive impact of this intervention on patient care and the work environment, this intervention strategy was not taken up within the organization. One of the reasons given was that of the commitment required to schedule staff and ensure staff attendance outside the nurses' work commitments (Beumer, 2008).

Wocial et al. (2017) published findings from an interdisciplinary discussion-based intervention directed at fostering open communication between team members in ethically challenging situations as a means of decreasing moral distress. The intervention was provided in the form of interdisciplinary team ethics rounds, and was focused, at a clinical level, on patients with an extended length of stay in the Pediatric Intensive Care Unit (PICU). Researchers identified greater ethical challenges with this patient population, due to increased chances for inconsistencies in management strategies, and the possibility for communication difficulties, due to delays in talking about sensitive ethical issues. The intervention took place over a period of 12 months, and involved weekly interdisciplinary ethical rounds facilitated by an ethicist; all professionals involved in the care of the patient were expected to attend these discussions. The intervention was measured using two different instruments. The Moral Distress Scale-Revised (MDS-R) was used to measure moral distress pre and post

intervention. Participants also used the Moral Distress Thermometer (MDT) on a monthly basis to rate their level of acute moral distress.

Researchers reported mixed results, because participants uniformly noted that participation in the intervention improved communication between team members, and they indicated an improved ability to communicate with patients and family members. However, the researchers were not able to report a statistically significant decrease in moral distress scores. This finding foregrounds the importance of gaining conceptual clarity on the definition of moral distress in order to develop interventions effectively to address the experience of moral distress. It may be that elimination of moral distress in ethically challenging situations is not possible. Instead, perhaps researchers ought to develop interventions aimed at supporting HCPs and teams navigating the experience without carrying the lasting negative effects of unresolved moral distress.

It is also worth noting that, in describing the setting for this study, the researchers describe the hospital context as having a robust training program for medical staff, while leadership at the program level is described as being supportive of medical and nursing staff and as having established a “strong trusting relationship between unit staff and the ethicist” (Wocial et al., 2017, p.78). These descriptors highlight how context may shape the research results and the individual capacity for moral agency.

Summary of interventions. The four intervention studies above, while important, also demonstrate some of the ambiguity that exists in our

understanding of moral distress. They further indicate the possibility that effective interventions may need to be tailored to the organizational and clinical setting. Only the study by Kalvemark Sporrang et al. (2007) included a combination of non-nursing HCPs, and clinical departments. Consequently, the intervention studies discussed above provide little insight into interventions that may be suitable across health care professions or settings, and offer no direction for promoting a collaborative approach to working through moral distress.

In order to move forward in developing effective interventions that support HCPs in fulfilling their moral obligations to their patients, we need to move away from the linear definition of moral distress discussed in Chapter One. Instead, we need to explore moral distress as an embodied experience that is a result of the interaction between and among the broader societal structures that shape health care delivery, organizational structures, and complex structures within the moral agent. A view of moral distress as a phenomenon that results from the interplay between structures and moral agents may allow the development of interventions that can attend to the specific context of the HCP as well as broader contextual issues. For example, Beumer's intervention which is an explicitly educational one focused on providing information and the development of self-care for nurses, actually positively impacted both patient care and the work environment. Working with the reciprocity that exists between structures and agents provides the potential to harness that reciprocity intentionally to create change in both the HCPs and the health care organization. In the next section, I point to the

literature that supports a view of moral distress as an embodied experience shaped by, and through, interaction with the health care environment.

Organizations. Much of the information provided above centers on internal structures and processes of the individual. However, woven through the discussion is recognition that an individual's internal environment is shaped, and continues to be shaped, by external contexts. In this final section, I turn to the work of Shay (1994, 2010, 2012) to explore the influences and consequences of organizations. I introduced the theme of reciprocal responsibility between organizations and HCPs in discussing the location of moral distress. The call for mutual responsibility and accountability in the provision of health care services clearly emerges from the research of Austin et al. (2003; 2005; 2008) as an appeal from all the HCPs involved in her studies. It also echoes research from outside the field of health care. Jonathan Shay is a military psychiatrist working with American soldiers returning from combat with a diagnosis of Post-Traumatic Stress Disorder (PTSD) (Shay, 1994). He found that the diagnosis of PTSD was inadequate to account for the destruction of moral character the soldiers experienced.

The concept of moral injury¹⁸ arises from Shay's work and provides a coherent example of challenges in the symbiotic relationship that exists between structures and agents. The notion of moral injury is defined as a betrayal of what

¹⁸ I recommend Shay's work on moral injury and direct the reader to his writing for a deeper understanding of his analyses (Shay, 1994, 2010, 2012). As well, Litz et al. (2009) have researched and written about the concept of moral injury.

is right by a legitimate authority in a high-stakes situation (Shay, 2012). Shay's support for the concept of moral injury is drawn from the fact that the military is a socially constructed organization created by society and defined by shared expectations and values. According to Shay (1994), the relationship between the military and their soldiers is based on the assumptions of shared risk of death, and a fiduciary assumption that the military will provide soldiers with the necessary information, equipment, supplies, and support to carry out their mission.

Moral injury in that situation resulted from a betrayal of both assumptions. I see several parallels to health care when drawing on Shay's work: health care organizations are social constructions involving shared values and expectations, and the drive for cost constraints and efficiency (along with HCPs being held accountable to a Code of Ethics and Standards of Practice that are not shared by health care organizations) have led to a sense of betrayal in the context of moral distress (Musto et al., 2015). I revisit these parallels in the Chapters Six and Seven of this dissertation and address them in terms of the GT I create on the basis of my research.

Another parallel I make with Shay's work reflects the impact that organizational behaviour can have on those in their employ. I am interested in the connection between organizational culture, neuroplasticity, and embodiment. The soldiers at the center of Shay's work experienced a destruction of character to the extent that they were unable to engage in the world as they had before they went to war (Shay, 1994). Given the above discussion on neuroplasticity,

the implication is that chronic stress and fear led to structural changes in the soldiers' brains. Shay's work suggests that the actions of an organization can permanently alter the character of an employee. My purpose in drawing on Shay's work is to reinforce the idea of reciprocal influence and mutual responsibility between structures and agents, in particular, structures that are socially constructed and then reflect the values and expectations of society (Musto & Rodney, 2018; Musto et al., 2015). While I am not suggesting that HCPs experience the same depth of trauma as soldiers in battle, I am suggesting that the sense of betrayal experienced by HCPs may be a significant element of moral distress (Musto et al., 2015; Rodney, Kadyschuk, et al., 2013).

It is my premise in this dissertation that we need to gain a better understanding of the interaction that occurs at the intersection of structures and agents in order to develop interventions that support ethical choices; interventions that support wholeness in HCPs and fulfill the fiduciary obligations of health care organizations.

Chapter Summary

In this chapter I provided an overview of the literature on moral distress in order to illuminate the gaps in our knowledge that need to be clarified if researchers are to be able to plan intentional interventions that support HCPs in fulfilling their moral obligations to patients. Lack of conceptual clarity in moral distress includes:

- gaps in our understanding of how moral agents move moral decisions to moral action;
- gaps in our understanding of the role of action in ameliorating moral distress; gaps in our understanding of the concept of what actually constrains action;
- an inability to tease out closely related concepts such as burnout and compassion fatigue from moral distress;
- a nascent understanding of the impact of moral distress on patient care, including the consequences of avoidance in relation to FTR;
- limited research on moral distress in mental health care; and
- no research on the impact of moral distress on patient care in mental health.

As I discussed at the beginning of this chapter, the issues of direct care delivery at a local level are a reflection of broader societal issues that underpin health care delivery. These issues include a global shortage of skilled HCPs, ideologies of cost constraint and efficiency, and neoliberal beliefs. In Canada, with the recent lapse of the Health Accord and a shift to a further decrease in the sharing of health care cost, local health authorities are going to be further stretched to constrain health care spending through increased efficiency. These efficiencies will increasingly challenge HCPs to provide care for their patients that align with their moral obligations.

The *Mid Staffordshire Trust Inquiry* (2013a) stands as a stark example of what can happen when HCPs are unable to enact their moral agency in an

environment driven by cost constraint and efficiency. It is worth noting that the patients who suffered most in the Mid Staffordshire Trust were the elderly, one of the most vulnerable patient populations. The acute health care system and community mental health system responsible for providing care for patients who struggle with mental health problems, also a vulnerable population, is chronically underfunded (Mental Health Commission of Canada, 2012). While there exists some research on moral distress with mental health professionals, no research exists that examines the impact of moral distress on the quality of patient care. This being the case, the research undertaken in this study is necessary in order to lay the foundation for effective interventions in moral distress.

Chapter Three Theoretical Framing

As is the case with most research projects, the proposed process for conducting research on moral distress in mental health care is shaped by the research question and how that question can best be answered. My research question centers on examining how HCPs enact their moral agency in the current health care climate. It was evident in Chapters One and Two of this dissertation that the experience of moral distress is not a linear process, but is influenced by various internal and external factors, leading to outcomes that may take different forms. A further premise is that the process, or experience, may be interrupted, and changed as new experiences occur.

Phrased another way, I assert that agents and structures exist in a reciprocal relationship and are changed as they interact with each other, and that they are changed according to the meaning the agent attributes to the interaction. In the context of moral distress, this means that the outcome of the experience cannot be predicted; rather, the outcome is dependent upon a confluence of circumstances and individual attributes. In speculating about the nature of structures and agents and the reciprocal relationship that exists between them, I assume that neither can be completely understood directly through the collection of only sensory research data. Instead, I believe that understanding structures and agents is a complex and layered process requiring the use of sensory data, as well as reasoned theorizing about the processes that

underpin this reciprocity, based on research from other disciplines such as neuroscience.

In this chapter I make explicit some of the assumptions underlying my research question, and lay out the theoretical framework that underpins my ontological, epistemological, and methodological research approaches. I review the ontological positions of positivism, post-positivism, and constructionism. Following this, I review my theoretical framing in the context of critical and relational inquiry, and critical realism. Finally, I address the implications of the theoretical framing for this research and link that framing to my selection of GT as a methodology. Grounded Theory Methodology (GTM), with roots in symbolic interactionism and pragmatism, will take into account the assumptions I identified above. However, before moving on to my ontological position, I further explore the foundational terms, such as structure and agency, that underpin my decisions regarding epistemological and methodological approaches.

Exploration of Foundational Terms

Structure

In much of the literature I have discussed in Chapters One and Two, the definition of structure was often just implied, leaving the reader to supply an explanation depending on the context. In reviewing the literature across nursing ethics, attachment theory, moral psychology, sociology, and neuroscience in relation to moral distress, I realized that both external structures in the health

care environment, such as resources, and structures internal to the individual contributed to constraining action, but that the constituents of internal and external structures may differ. In other words, some structures were material or observable (e.g., written policy), and other structures were non-material and not directly observable (e.g., internal psychological processes), yet both forms of structure influenced the agent's ability to act. Inadequate policy, or policy that conflicts with professional or personal values, may form material and observable structures that constrain action and result in moral distress. Thus, an observable example may be hospital policy that results in an inadequate ratio of Registered Nurses (RNs) to acutely ill patients (Musto et al., 2015; Musto & Schreiber, 2012; Storch et al., 2002). Hierarchical relationships imbued with power within health care teams are examples of structures that are not observable yet also constrain the actions of others (Deady, 2012; Jameton, 1984). Both of these examples reflect external constraints that inhibit action. However, understanding observable and unobservable structures is necessary but not sufficient; such understanding does not illuminate the relationship of agency, or how agency could effect change in these circumstances.

To adequately define structures, then, I begin with some of the literature in sociology. Specifically, I draw on both the social sciences and the natural sciences. In what follows, I explain that I view structures as being both material and non-material, as having emergent properties, and having the capacity to have influence. In using this definitional framing, I understand structures to

extend from the external environment in which the agent lives and works, to the deeply internal environment of the agent.

Structures as material and non-material. Theorists from sociology¹⁹ have grappled with a definition of structures and note ongoing ambiguity with the existing definition (Elder- Vass, 2008; Sewell, 1992). Sewell (1992), a political scientist and historian, identified what he viewed as, “the three cardinal weaknesses” (p. 3) of structure in the social sciences. He sees the weaknesses as failures:

- (1) to recognize the agency of social actors;
- (2) to build the possibility of change into the concept of structure; and
- (3) to overcome the divide between semiotic and materialist views of structure (p.3).

Accounting for agency and the possibility of change are both relevant to my discussion, and so I will draw on Sewell’s perspective on the duality of structures to support my understanding of structure in the context of my dissertation.

In discussing the duality of structures, Sewell (1992) is drawing on Giddens’ structuration theory, which posits structure as both a medium and an outcome. This means that, “structures shape people’s practices, but it is also people’s practices that constitute (and reproduce) structures” (Sewell, 1992, p.

¹⁹ Because my purpose is to discuss structure(s) in relation to moral distress, I will provide an overview of the discussion on the definition of structures mainly as it pertains to moral distress. From a critical realist position, Archer (1998) and Edler-Vass (2008) theorize about the relationship between structure and agency in the context of change and point to the emergent properties of structures. Please see Sewell, Elder-Vass or Archer for a comprehensive discussion on structure in the social science literature.

4). Inherent in this definition is the idea of reciprocity between structures and agents. Sewell interrogates Giddens' definition of structure and finds it somewhat ambiguous. In order to maintain the central theme of the duality of structures, Sewell conducts a careful exegesis of Giddens' definition and draws on Bourdieu's idea of *habitus* in order to re-conceptualize a theory of structure that will account for the weakness identified above.

In his definition of structures, Sewell (1992) maintains the central theme of the duality of structures and states that structure "should be defined as composed simultaneously of schemas, which are virtual, and of resources,²⁰ which are actual" (p.13). For my purposes, I retain Sewell's understanding of structures as having a dual character, being both virtual (non-material) and actual (material), and agree that structures in both forms can be understood to exert an influence on agents.

However, in extending the definition of structures to include the internal environment of the agent as well as the external environment, I move away from a strictly sociological understanding of structures to a general definition of structures incorporating biological, physiological, and social elements, and processes. I elaborate on these concepts when I discuss structures as internal and external.

²⁰ It is not my intention to critique Sewell's theory, however, I believe that one of the weaknesses in the theory is that he defines resources solely as material. Psychological resources, for example resiliency, may also be seen as a resource. I view resources as both material and non-material. Support for this view of psychological resources can be found in the work of Allan Schore (2003) and Dan Siegel (2012).

Structures as emergent. I also view structures as having emergent properties. Elder- Vass (2008) draws on critical realism to explain structures as social wholes that possess emergent properties. Key to this conception of emergence is the understanding that emergent structures are not reducible to their parts (Cruickshank, 2012; Elder- Vass, 2008). A common example used to describe emergence is found in the natural sciences: water is considered an emergent property of hydrogen and oxygen but is not reducible to either part (Cruickshank, 2012). Viewing structures as emergent is one way to explain how change may occur in the relationship between structures and agents.

Although Sewell does not use the terminology I have used when theorizing change, he identifies five key axioms (or emergent properties) that come together in contingent ways to generate a transformation of structures (Sewell, 1992). Agency is a central element that influences the contingent way in which these emergent properties come together to influence structures. He views agency as “the actor’s capacity to reinterpret and mobilize an array of resources in terms of cultural schemas other than those that initially constituted the array” (p.19). It is important to note that the concept of taking action based on interpretation of the situation also echoes the three premises of symbolic interactionism (SI) articulated by Blumer (1969), which are that (a) people act toward things based on the meaning these things have for them, (b) the meaning of things is derived out of social interaction, and (c) meaning is handled in, or modified through, an interpretive process. Inherent in Blumer’s three premises and Sewell’s definition of agency, is the idea of a knowledgeable actor making

intentional choices. Also evident is appreciation of the contingent ways in which structures and agents come together and shape each other.

The interaction between agents and structures necessarily becomes the site of research in order to tease out the contingent way in which agents and structures influence each other. Consequently, for my research, a methodology that focuses on understanding meaning and action, and considers the broader sociological context that shapes meaning and action was needed. As I have indicated earlier, GTM is designed to examine process, interaction, and the meanings participants give to the situation. Depending on the orientation and purpose of the researcher, a critical perspective in GT can be brought to the study examining the structural processes and conditions that shape the context (MacDonald, 2001). For my research, the consequences of viewing structures as emergent meant recognizing that the development of structures internal to the agent are shaped by, or contingent on, emergent properties such as genetics, temperament, family upbringing, and the external environment.

Structures as internal and external. To define structures, I began with sociology, and a sociological explanation of social structures external to the agent. Specific to my research, political ideologies that shape health care culture, policies, and unit culture are some of the external but often unobservable structures that shape the health care environment of participants. Ideologies may include neoliberalism, or the dominance of a market model, in which efficiency, and cost effectiveness underpin policy in the delivery of health services (Austin, 2011; Pauly, 2013; Rodney, Harrigan, et al., 2013; Rodney & Varcoe, 2012). The

Lean Model has been adopted in health care service delivery from the business sector and some health care researchers question the appropriateness of applying a business model to health care delivery (Austin; Rodney & Varcoe). Other external structures that shape health care delivery include, but are not limited to, resource allocation, power and gender inequities, and organizational policy (Rodney, Harrigan, et al.; Sherwin et al., 1998).

As I have argued above, for my research, I wanted to extend my study of structure from external to also include structures *internal* to the agent. The internal structures I am referring to are the biological, physiological, and psychological objects and processes such as cells, tissue, organs, hormones, biological systems, emotions, cognition, ideas or concepts, and so forth that influence the internal state of the person. When the definition of structures is limited to the external environment, what is actually occurring within the individual is overlooked. In extending our appreciation of structures to include the internal environment of the individual, moral distress as an embodied experience can be intentionally explored.

I divide internal and external structures at the boundary of the body. However, I acknowledge that this may be a somewhat artificial boundary, as research from the human sciences and medicine demonstrates that the external environment can have a significant effect on the internal structures of the body (Mate, 2011). An example of the interplay between external and internal structures is seen when exposure to environmental stress (for example, conflictual relationships), can increase the body's vulnerability to disease (Mate,

2011; Sapolsky, 2004). The impact of stress on the body is a negative example of how external structures can have a negative influence on internal structures; however, the opposite is also true. Research on attachment demonstrates that attuned caregivers support neural growth in areas of the brain responsible for emotional regulation (Schoore, October 2005; Siegel, 2012).

My purpose in extending the definition of structure to include internal as well as external components is to highlight the embodied nature of agency. In the context of health care delivery, constraints on the enactment of moral agency are complex and likely to be a combination of internal and external factors. An example of external and internal structures constraining action may be seen in an interaction between a HCP and his or her manager. If a HCP is unable to provide adequate care due to lack of resources, (e.g., supplies, space or time), and believes the way to address this situation is to speak to his or her manager, he or she may be constrained from action due to anxiety or fear of conflict.

Alternatively, he or she may criticize others who are trying to take positive action by listening to patient and family concerns (Rodney, Kadyschuk, et al., 2013).

Significantly, both forms of structure also shape each other and are central to the concepts of taking action and creating change. Of importance for my discussion is the recognition that structures—material and non-material, as well as internal or external—have a direct bearing on the role of action in the experience of moral distress. In other words, the experience is embodied as well as emotional.

Moral Agency

Moral agency has been described as an individual's capacity to direct his or her actions to bring about a moral end (Storch, 2013). Central to the experience of moral distress is the concept of *constrained agency* (Rodney, Kadyschuk, et al., 2013; Rodney & Varcoe, 2012). Jameton's conception of the experience of moral distress is that it manifests as a consequence of not taking action (Jameton, 1984, 1993; 2013). As I noted in Chapter Two, gaining insight into the role of action in the experience of moral distress may help in the development of interventions. Our understanding of agency in bioethics is evolving in response to the feminist critique of the concept of action (Peter, 2011; Rodney, Kadyschuk, et al., 2013; Sherwin, 1998). Historically, in the bioethical literature, agents have been portrayed as independent and self-determining individuals with little attention paid to how context influenced their decisions (Rodney, Kadyschuk, et al., 2013; Sherwin, 1998). Feminist critique has called attention to how the traditional views of agency obscure the sociopolitical context in which decisions are made and, instead, call for a relational approach to health care ethics (Sherwin, 1998). The consequence of this critique for my study was that I needed to attend to how the context of the health care environment shapes meaning and action for the participant (agent).

Earlier in this chapter, I presented Sewell's definition of agency, which was built on a person's capacity to make new meaning out of a situation and mobilize resources (Sewell, 1992). Sewell's definition also suggests that taking action is a component of agency. However, agency cannot be discussed separately from

autonomy. Indeed, Sherwin (1998) identifies the interdependence of the two concepts as she argues for a relational approach to autonomy. Sherwin defines agency as “the making of a choice,” and autonomy as, “self-governance” (p. 33). The concept of autonomy is used to discuss both a developmental process in early childhood, as well as a bioethical principle.

Given my understanding of agents as embodied, the developmental process of autonomy is clearly linked to self-governance in adulthood. Theorists have pointed to autonomy as a biological and physiological process that is shaped by experience with the external environment, particularly interpersonal relationships (Erikson, 1997; Narvaez, 2014; Ryan, Kuhl, & Deci, 1997; Schore, 2005). Consequences of autonomy as a developmental process relate to a person’s capacity for self-regulation (self-governance) (Ryan et al., 1997). Self-regulation, or the ability to manage emotional states (Siegel, 2012), is foundational to reasoning, making choices, and taking intentional action. This understanding of the relationship between autonomy and self-regulation in the context of taking intentional action to alleviate moral distress has implications for the health care environment. As well, awareness of the influence of interpersonal relationships on an individual HCP’s ability to regulate may be a site for interventions.

Woven through the above discussion defining structure and agency are the ideas that the actions taken by HCPs in morally distressing situations are shaped by a reciprocal relationship between internal and external structures, and are based on meaning that is contextually and relationally situated. In presenting

action from this perspective, I take the position that action is contingent on a variety of elements (Nairn, 2012); therefore, what can be known empirically about the influence of taking action on the experience of moral distress is contingent on both the internal context of the HCP and the health care environment. Keeping this discussion in mind, and building on my earlier discussion in the next section I situate my ontological positioning for this research within critical realism.

Ontological Positioning

In order to establish congruency between ontological and epistemological approaches, it is necessary to make explicit the beliefs about the nature of reality and how knowledge is developed that guide me in this research. I begin with a brief overview of positivism, post-positivism, and constructionism, and then outline my reasons for taking up a constructionist position.

Positivism

Although Alversson (2009) and others have argued that a strictly positivistic approach to science is dead in our current era, positivist assumptions in the form of randomized control trials as the gold standard for research remain prevalent in our current health care system (Goldenberg, 2006; Upshur, 2005). A positivist view of reality is based on the assumption that reality and the causal laws underpinning reality are waiting to be discovered, and function in a linear and predictable manner. A positivist approach to health care is based on the assumption that population health, interventions, and changes in health status can be quantified, and that they occur in a linear, cause and effect, fashion. In

the context of moral distress, a study conducted from a positivist perspective could measure the frequency and intensity of moral distress but would not be able to tell us about the meaning of the experience. A positivist belief that events occur in a linear fashion is based on a view that a concrete reality exists outside of our thinking (realism), and is ordered and governed by a set of unchanging laws. The corollary of these beliefs is that these laws can be discovered through rigorous application of the scientific method. In keeping with positivism, the central tenets of the scientific method are objectivity, measurability, and verification (Polifroni & Welch, 1999).

Critiques of positivism assert that it is mechanistic and reductionist as, in order to determine causation, context must be stripped from the situation (Crotty, 1998; Goldenberg, 2006). Further critiques include the separation of fact from value, and the placement of the researcher in the role of an objective observer who has no impact on the objects under study (Charmaz, 2006; Crotty, 1998; Yeo, 1994). The idea of objectivity incorporates the belief that these unchanging laws are a-contextual and a-historical (Agger, 1998; Crotty, 1998). An accompanying assumption is that rigorous application of the scientific method will eliminate researcher bias that may taint the objectivity of scientific findings. Scientists' and philosophers' critiques of these positivist claims have resulted in a movement toward a "softer" form of positivism known as post-positivism.

Post-Positivism

Post-positivism emerged out of positivism and takes a more tentative stance in its claims to truth and knowledge. Post-positivism maintains the belief

in the existence of a single external reality, but concedes that reality cannot be fully apprehended through empirical means (Crotty, 1998). Rather, use of empirical methods will lead to an approximation of reality that we cannot come to know fully because of hidden variables and a lack of absolutes (Lincoln, Lynham, & Guba, 2011). As well, a post-positivist maintains the position of the researcher as a disinterested observer out to discover new knowledge, thereby holding on to the belief of some level of objectivity in research. Philosophers such as Kuhn (1977) have successfully argued the untenability of the positivist position of objectivity and the separation of facts from values by demonstrating that scientists are historically and culturally situated and, as such, are active participants in the construction of knowledge (Agger, 1998; Crotty, 1998). Despite a softening of a positivist stance, post-positivism is still based upon using empirical methods in the discovery of knowledge. This means that results from empirical studies on moral distress remain at a descriptive level, which makes a quantitative approach inadequate for the exploration of complex phenomena such as how HCPs manage morally distressing situations in practice.

Constructionism

In my exploration of constructionism as an ontological position for this research, I have grappled with the difference between constructionism and constructivism. My exploration revealed that these concepts remain contested, and developing an understanding of them is complicated by the fact that researchers and scholars write about these terms in different ways. For example, in Denzin and Lincoln's (2011) text entitled *The Sage Handbook of Qualitative*

Research, the idea of constructing knowledge falls primarily under a constructivist heading in which social critique is central. Lincoln, Lynham and Guba (2011), in their constructivist paradigm, hold to the belief that knowledge construction is an intra and interpersonal process, and results in the existence of multiple realities, or multiple truths; thus, no single reality takes precedence.

This view of constructivism clearly falls into a subjectivist and relativist paradigm. An individualist approach to the production of knowledge fails to account for the influence of social structures on individual meaning-making and action (Browne, 2001; Clark, Lissel, & Davis, 2008; Cruickshank, 2012). As I planned to examine how moral agents take action in the context of the structures in which they work, I needed to be able to account for the influence of social structures. Another difficulty with constructivism is that a critique of culture, society, and the structures that frame and influence the creation of meaning and knowledge becomes impossible if the only knowledge that counts is created individually (Crotty, 1998). Yet, as I noted earlier, critique of assumptions that underlie our current system of health care delivery, along with the power structures that maintain these assumptions, is imperative if change is to occur.

Crotty (1998) takes a different approach to that taken by Denzin and Lincoln (2011), making a distinction between *constructionism* and *constructivism*. He describes constructivism as an individualistic understanding of constructionism. Crotty (1998) contends that constructionism is opposed to the belief that knowledge is revealed or that knowledge inherently resides within an object, but instead arises from the belief that all knowledge is constructed and

that construction of knowledge occurs through interaction with the object. In describing constructionism, Crotty portrays an active and reciprocal relationship between the object and the individual, as he parallels constructionism with intentionality. When used in this way, intentionality is a “radical interdependence of subject and world” (Crotty, 1998, p. 45). He also points out that individuals are born into a cultural system that already tells us how to engage with the object.

From this perspective of knowledge, the idea of understanding the *meaning* that is attributed to an object, and how that meaning is developed, becomes integral to the research process. Understanding how HCPs construct meaning regarding their moral obligation(s) to their patient may provide insight into how health care policy constrains or supports their fulfillment of these obligations. Consequently, it was important that I chose a research methodology that allowed me to be attentive to the importance of the meanings ascribed to a situation or an object.

The origins of grounded theory (GT), the methodology I have chosen for the study, are in symbolic interactionism (SI) and pragmatism²¹. Central in SI is the interdependence between subject and object in the understanding of meaning (Blumer, 1969). Woven through constructionism and SI is the idea of *agency*—that people have the capacity to interpret a situation and take action.

²¹ The roots of grounded theory (GT) are contested by one of the originators of the method, Barney Glaser. Several researchers in GT have successfully argued that symbolic interactionism and pragmatism were built into the foundations of GT through Anselm Strauss, the co-originator of GT. The writings of Charmaz (2006), as well as Milliken and Schreiber (2001, 2012) offer more in-depth accountings of the debate.

The interpretations people make are socially constructed and reflect cultural, political, and economic contexts, at the same time allowing individual differences in the meaning that is made. As such, researchers taking a constructionist stance, including SI, would acknowledge the historical, situational, and contextual influences on the research, and would view themselves as co-participants in the research and in the construction of knowledge (Lincoln et al., 2011).

I took up a constructionist approach and operationalized that approach through GT, as it allows for the development of *collective* meaning but does not preclude the experience of the *individual* meaning-making and action-taking derived from that meaning. This perspective has important ramifications both for theorizing about how change may occur in the context of structure and agency in relation to moral distress, and for my choice of research methodology, which I will elaborate on in this chapter as well as in Chapter Four.

What I take from Crotty's discussion of constructionism is the idea that knowledge is constructed but does not preclude the belief in an obdurate reality; however, a constructionist position acknowledges the existence of multiple interpretations and meanings of reality (Crotty, 1998). Second, I understand that the idea that the theories derived from a constructionist stance reflect our experience of reality. Social constructionism, with its emphasis on understanding how culture shapes the collective development of meaning, simultaneously invites critique of what societies accept as truth and how they came to that truth. This kind of critique allows for the uncovering of the hidden assumptions and power structures that hold practices and beliefs in place. Once these

assumptions and power structures become transparent, choice, action, and change become possible (Kincheloe, McLaren, & Steinberg, 2011). This means that intentionally exploring how the health care context shapes the enactment of ethical practice may reveal avenues for the subsequent development of interventions that support HCPs in fulfilling their moral obligations to those in their care. When I move into the epistemological section of this chapter I draw on critical theory and relational inquiry as means of intentionally critiquing power within the health care system.

Application of the Ontological Position

Critical Inquiry

The focus of my research is explicitly ethical and my purpose is to generate the understanding, beginning with this dissertation, that is the prerequisite for the creation of change in the health care environment. The research I conducted is necessarily one that critiques the relationship that exists between health care providers and health care organizations. The purpose of critical inquiry is to bring about social change. Critical inquiry, thus, is designed to seek understanding in order to effect change and movement toward a just society. By taking a critical perspective, I recognize the importance of context in shaping the understanding of, and the meaning that, situations have for the individual or actor. In order to bring about change using a critical lens, I examined cultural, and societal structures, and the assumptions that underpin structures and customs, through a variety of perspectives with the purpose of revealing the

power relationships that maintain the status quo. Examples of critical lenses are feminism, gender, discourse, and economics (Agger, 1998; Crotty, 1998; Denzin & Lincoln, 2011).

In critiquing structures and assumptions for the purposes of change when I take a critical perspective, I necessarily reject a positivist stance and the belief in the existence of natural laws that determine human behaviour and the order of society (Agger, 1998). Instead, with a critical perspective, I hold to a belief that human behaviour, culture, and the social structures that exist at any given time in history are socially constructed and open to change. Thus, the purpose of critique from a critical perspective is emancipatory. It is a movement toward a just society through the raising of consciousness regarding oppressive structures and practices in the current age (Agger, 1998; Crotty, 1998).

Beliefs about how change is brought about are reflected in the specific critical approach the researcher brings to the research. For example, some researchers believe that being involved in the research process itself will increase awareness for both the participant and researcher which would lead to change, whereas other critical perspectives may call for political action (Kincheloe et al., 2011). What this means for my study is that, while my purpose was to generate knowledge that would lead to interventions in moral distress, the process of engaging in the research may have created change for those involved in the study.

Regardless of the specific critical perspective held by the researcher, the results that are hoped for include change that leads to transformation such as

emancipation, equity and social justice (Crotty, 1998; Denzin & Lincoln, 2011). In this study, I anticipated that using a critical lens would ultimately facilitate change by exposing some of the overt and covert power dynamics that exist within the health care system, and influence the behaviour, and expectations of both the employer and health care professionals. This examination of the power dynamics will also encourage the challenging of the assumptions that underpin, and hold in place, these dynamics, such as the neoliberal ideology that underpins current policy in health care service delivery. Also critical in recognizing the extent to which power influences choice and action within health care is the importance of understanding how health care professionals are relationally situated within their world, which, in turn, may enhance, or inhibit an HCP's capacity to enact his or her moral agency. Therefore, in examining moral distress, it has also been important to explore the web of relationships in which each participant was situated.

Relational Inquiry

I argued during the literature review (in Chapter Two) that people are shaped by both internal and external influences that impact their capacity for agency. External influences that affect a person's capacity for decision-making and perspectives of personhood are relational in nature and include cultural, socioeconomic, and sociopolitical structures. In this context, I use the term *relational* to refer to the interpersonal relationships that an individual may take into consideration as they enact their decision-making. I also include the interpersonal relationships that influence the processes an individual engages in

as they make these decisions. In a feminist critique of the concept of autonomy, the philosopher, Sherwin (1998), outlined the implications of using a relational conception for understanding how social forces shape the development of self-identity that is instrumental in the enactment of moral agency. In what follows, I elaborate on how I used relational inquiry to enrich our understanding of agency.

Feminist and other relational theorists have challenged the traditional view of an agent as an independent, self-determining individual who makes decisions based solely on rationality (Hoffmaster, 2001; Jaggar, 1991; Rodney, Kadyschuk, et al., 2013; Sherwin, 1998). Following the lead of such theorists, over the past two decades, scholars in nursing have explored what it means to be a moral agent from a relational context, acknowledging that individuals are contextually situated and that actions and decision-making are inseparable from context (Austin, 2011; Doane & Varcoe, 2013; Gadow, 1999; Rodney, Kadyschuk, et al., 2013). As I noted in Chapter One, the term “relational” is taken up in two distinct ways in the nursing practice and nursing ethics literature. The first way refers primarily to interpersonal relationships, or the quality of the relationships that exist between individuals (Bergum, 2013; Bergum & Dossetor, 2005). Bergum (2013) provides an example of “relational” with a focus on interpersonal relationships. In her discussion on relational ethics, Bergum focuses on the moral space that exists between people. She is also clear that focusing on interpersonal relationships as the place for moral action occurs at all levels of the health care system, stating that, “[e]thics at the bedside and ethics in the system are part and parcel of the same lived universe. The moral community includes

each of us as responsible for our actions in relation to the people we care for, educate, supervise, or work within partnership” (p. 128-9). Similarly, Jonsdottir, Litchfield, and Pharris (2004) recognize the interpersonal relationship, and the therapeutic relationship in particular, to be the core of nursing practice, and investigate ways to strengthen this aspect of practice.

A difficulty with an exclusive focus on this interpersonal relationship perspective of relational inquiry is its emphasis on the individual nurse’s responsibility for developing and maintaining the therapeutic relationship, as well as for effecting change within the health care system (Doane & Varcoe, 2013). That focus is necessary, but not sufficient, to acknowledge how broader systems impact a nurse’s ability to form interpersonal relationships. The repercussions of focusing on the ability of the individual nurse is that the causes and experiences of moral distress can be viewed primarily at the individual level, leaving the health care organization absolved of its responsibility to provide an environment that supports nurses’ enactment of their moral agency as an intrinsic aspect of nursing care.

The second way that “relational” has been taken up in the nursing and health care literature refers to the reflective examination of the multitude of factors that shape the relationship between the individual patient and the nurse (Doane & Varcoe, 2013). These factors include, but are not limited to, the context of the situation, the environment, and the sociopolitical and economic ideologies and power dynamics that influence health care delivery (Doane & Varcoe, 2014; Rodney & Varcoe, 2012; Sherwin et al., 1998). Viewing nursing and health care

provider practice overall from this broader relational perspective addresses the quality of the relationships that exist between individuals. Further, a relational perspective encourages us to examine how power is imbued in the health care system, and how that system supports or places barriers to the development of interpersonal relationships and health care practice in general.

In examining broader structural power dynamics, the responsibility for better health and health care outcomes shifts from being merely the responsibility of the individual care provider to being a responsibility shared, at least to some extent, with all stakeholders at all levels of the health care and social system. An example from mental health that may lead to moral distress is the development of the therapeutic relationship, or the relationship between an HCP and a patient that is focused on advancing the best interests of the patient. The obligation for developing the therapeutic relationship is that of the HCP and how he or she engages with the patient, as well as the responsibility of the health care organization to supply adequate resources so the HCP has the time to develop the therapeutic relationship.

My aim in this dissertation is to bring some conceptual clarity to our understanding of moral distress in order to move forward, in an intentional way, with the development of effective interventions. In order to accomplish this, I believe it is necessary to understand how structures and agents mutually influence each other in the enactment of moral agency, which necessitates the exploration of the meaning of moral distress of HCPs who have experienced it, and the critical examination of the sociopolitical structures that influenced the

experience. Grounding this research in the language of structure and agency conveys the idea of a belief in an obdurate reality, the belief that both structures and agents exist in the world. At the same time, understanding meaning and processes from the perspective of the participant upholds the belief that knowledge of the world is socially constructed.

In applying a social constructionist lens to moral distress, I am not suggesting that moral distress is *only* socially constructed; I am, instead, arguing that the *meaning* given to the experience, and the subsequent action, is socially constructed. I also bring a critical perspective to this research in order to attend to the power dynamics existing within health care that influence decision-making and the maintenance of the status quo. Further, I conducted this research from a perspective of relational inquiry, as I believe that processes and meanings need to be understood in the context in which they were created. In what follows I describe my research in the context of critical realism through my proposed use of critical theory and relational inquiry.

Methodological Application: Critical Realism

Understanding the relationship between ontology and epistemology is central to conducting research from a critical realist perspective. Bhaskar (1975) put forward a central argument in critical realism that science often conflates the object, in this case moral distress, under study with what is known about the object. Bhaskar seeks to shift our emphasis on knowledge from an epistemological focus to an ontological one (Nairn, 2012). In order to shift our

focus from how we might come *to know* an object to the object itself, Bhaskar states that, “Philosophical ontology asks what the world must be like for science to be possible” (p. 36). I thus examined moral distress from an ontological position starting with the question: “What must moral distress be for the experience to occur?” A critical realist approach to research is to theorize about the object under study and then to draw on the epistemological approaches that are best suited to investigating the theory (Nairn, 2012).

McEvoy and Richards (2003) summarize four of the main features of critical realism, drawing on the work of the philosopher, Bhaskar. I present the features of critical realism, applying each tenet to moral distress to provide an example of how this approach helped to clarify the concept. The first feature is that of *generative mechanisms*. Critical realists view causality as complex and state that what is observed reflects generative mechanisms— structures, powers, and relations—beneath the surface that come together in a particular combination or context to generate an event (Bhaskar, 1975). In this way, generative mechanisms may be thought of as causal laws that exist in the natural and social worlds; however, their consequences are not always observed at an empirical level (Bhaskar, 1975; Blom & Morén, 2011). Instead, the effects of generative mechanisms are conditional, based on the surrounding context, and therefore may remain latent depending on circumstances (McEvoy & Richards, 2003).

Although generative mechanisms are not directly observable, they do exist and have an influence on the empirical world (Bhaskar, 1975; Blom & Morén,

2011; McEvoy & Richards, 2003). The purpose of research from a critical realist perspective is to theorize about generative mechanism and speculate about the conditions in which the generative mechanisms may be observed (Blom & Morén, 2011; Pawson & Tilley, 2004). The concept of moral distress provides an example of the complexity of causality. As I have argued earlier in this dissertation, although there is agreement regarding some of the contributing factors such as HCPs having an awareness of their moral obligation yet being unable to enact their moral agency due to constraints, researchers continue to grapple with how individual and structural factors come together to create moral distress in some situations and for some people, but not others (Austin et al., 2005; Hamric, 2012; Lützén & Kvist, 2012; Varcoe et al., 2012).

The second feature of critical realism is the belief in a *stratified ontology*. In critical realism, reality is viewed as differentiated across two dimensions (Danermark, 2002). First, reality is stratified into three domains: a) the empirical, which we experience; b) the actual, where conditions come together but we may not see them; and c) the real, where generative mechanisms exist (Clark et al., 2008; Littlejohn, 2003; McEvoy & Richards, 2003; Wainwright, 1997). The second dimension of stratification occurs because reality is constituted of “hierarchically ordered levels where a lower level creates the conditions for a higher level” (Danermark, 2002, p. 57). However, the higher levels of reality cannot be reduced to the lower level components that make up the higher level.²²

²² For further discussion of the stratified levels of reality in critical realism and how this is applied in moral distress research, please see Danermark, 2002 and Musto and Rodney, 2015.

Although critical realists assume an external reality, they reject a simplistic version of empiricism that limits reality to what can be experienced. Instead, critical realists assert that what can be experienced is “only a portion of what actually happens in the world. And what actually happens is only a small proportion of what could potentially happen, given the right combination of underlying mechanisms that exist in reality” (Littlejohn, 2003, p. 450). Critical realists accept that the underlying causal mechanisms may be complex and that a variety of conditions influence causal mechanisms in contingent ways, thereby changing the outcome at the level of observable events. The idea of causal mechanisms coming together in contingent ways has significant implications for researchers and knowledge development.

One of the implications is that researchers ought not to look for strict regularities; rather, they should be looking for semiregular patterns, and underlying causal mechanisms (Angus & Clark, 2012; Clark et al., 2008). Another implication for researchers is in regards to assumptions; we cannot assume that because we don't see evidence of moral distress at an empirical level, that it is not occurring at the actual level of reality. In terms of research on moral distress, there is a need to look for variations in the experience in order to theorize about the conditions and contexts that come together and influence the underlying mechanism to result in what is observed and experienced by health care providers.

The third feature of critical realism that will support my study of moral distress is *the dialectical interplay between social structures and human agency*,

focusing on the interdependence of structure and agency (Archer, 2007; Clark et al., 2008; McEvoy & Richards, 2003) that I pointed to in my earlier discussion of Sewell (1992). From a critical realist perspective, social structures have the capacity to both inhibit and enable individuals to act through the distribution of resources, yet agents also have the capacity to influence these social structures (Nairn, 2012). In the context of moral distress, as I pointed to earlier, some of the external constraints that influence health care delivery include the discourse on economics, efficiency, and managerialism; however, health care providers respond in overt and covert ways that either support or interrupt these structures in an effort to create change (Rodney & Varcoe, 2012). It is my argument in this chapter that an important factor in developing conceptual clarity in our understanding of moral distress is a closer examination of the reciprocal relationship between social structures and the enactment of moral agency. That is, we need to understand better how agents can affect structures and vice versa, which is foundational to making constructive social change (Musto et al., 2015; Sewell, 1992).

Finally, the fourth feature presented is *a critique of the prevailing social order* (McEvoy & Richards, 2003, p. 412). Cruickshank (2012) identified the use of critical realism as a means of criticizing illegitimate practices and of improving existing theories through criticism. McEvoy and Richards also note that, although taking up critical realism does not necessarily “entail a commitment to a specific theory or sociopolitical agenda” (p. 413), critical realism can be used to examine how structures maintain social inequities. In health care, these structures include

the discourse of reductionist demands for a cost effective and efficient health care system. For the purpose of examining the complex phenomenon of moral distress, I took up a critical perspective in my analysis to examine the structures in which health care is provided, with attention to the power relationships that influence the delivery of care.

Bridging Post-Positivism and Constructionism

The examination of power relationships within structures assumes that power both shapes human behaviour, and that a power balance is dynamic and can be shifted or changed. Some of the questions relevant to my use of critical realism in this research were related to how critical realism bridges the gap between post-positivism and constructionism. In positioning critical realism, proponents draw on the strengths of positivism and constructionism, yet, at the same time, they reject the limitations of each paradigm (Clark et al., 2008; Cruickshank, 2012). Some adherents of critical realism place it within a post-positivist paradigm (Cruickshank, 2012), while others position it beyond post-positivism by setting out “a much more distinctive alternative to positivism and relativism” (McEvoy & Richards, 2003, p. 412). Critical realism shares a positivist foundation with post-positivism; however, it moves beyond post-positivism and the critiques of positivism by explicitly incorporating constructionist approaches into its perspective on truth and the production of knowledge (Clark et al., 2008; McEvoy & Richards, 2003; Nairn, 2012).

In constructionism, the *meaning* of an object is conferred upon an object through interaction (Crotty, 1998). Of note to critical realism in the preceding statement is that objects exist regardless of our knowledge of them, but it is through interaction with the object that it comes to hold a particular meaning for people. Meanings, and by extension knowledge, are socially constructed, therefore they are historically, politically, and culturally situated. Thus, knowledge is considered contextual and evolving (Crotty, 1998). Critical realists recognize the importance of understanding how context influences meaning in the construction of knowledge; this applies across both the natural and the social science worlds (Bhaskar, 1975). Understanding context is key when using a critical realist approach because of the recognition that generative mechanisms are activated or not activated, depending on context. Pawson and Tilley (2004) describe a critical realist approach to program evaluation that utilizes “contextual thinking to address the issues of ‘for whom’ and ‘in what circumstances’ a programme will work” (p. 7).

Taking into consideration the constructed nature of knowledge, and understanding the contextual influences on moral distress through my use of critical realism in this research, will help researchers accurately theorize about the conditions that give rise to the experience, which Hamric (2012) notes that such theorizing is a prerequisite to developing targeted strategies to intervene. Understanding the meaning HCPs attribute to situations in which they feel constrained or supported in the enactment of moral agency, and theorizing about

these conditions, were central to my considerations regarding choice of methodology.

Some of the concerns with constructionism expressed by critical realists include a structuralist position and the potential for relativism, whereby knowledge is held to be subjective and individual (Wainwright, 1997). A constructionist approach to knowledge development, if taken to an extreme, includes the belief that individuals are not only socially constructed, but that they are *determined* by social structures. To counter this claim, critical realists point to the reciprocal relationship between and among individuals and structures, stating that social structures emerge from “the actions of individuals and then exert a causal influence over individuals” without determining them (Cruickshank, 2012, p. 73). In positioning moral distress within a critical realist perspective, I am claiming that moral distress is underpinned by generative mechanisms and that it exists regardless of our knowledge of it. This means that I view moral distress as existing but not necessarily activated unless aspects of the internal and external environment come together in a particular way to activate moral distress. In this way, the experience of moral distress is activated and observed at the empirical level in the context of the reciprocal relationship between structures and agents.

Foundational to the belief that there is a reciprocal relationship between structure and agency is accepting that structures and agents are both open systems with the capacity to change and be changed (Bhaskar, 1975; Pawson & Tilley, 2004). Notwithstanding its ground-breaking importance, in the original definition of moral distress, Jameton (1984) somewhat naively suggested that

nurses were unable to enact their moral agency when confronted by external constraints. As I have argued in Chapters One and Two, understanding the relationship between structures and the enactment of moral agency continues to be problematic. In more recent research on constrained agency, Rodney and Varcoe (2012) argued that nurses take both overt and covert action when confronted by situations and policies driven by sociopolitical ideology that inhibits their ability to provide care in the best interest of the patient. Although moral distress was not the main focus of their work, moral distress emerged as a consequence of efficiency-driven policies for the nurses in their studies. As well, the nurses' response to these policies demonstrates that nurses, as agents, find creative ways to respond to situations that challenge their moral obligations to the patient, and these responses were not necessarily pre-determined by these structures. For example, in their study, Rodney and Varcoe noted that some nurses actively defied policy that interfered with their ability to provide good care (2012). It has been my premise in this study that applying a critical realist lens to the examination of the reciprocal relationship between structures and agents allows researchers to view the relationship as dynamic, and encourages a greater understanding of how the interplay between structure and agency may create change.

The second concern with a constructionist approach is that of relativism. While not all knowledge that is constructed is subjective (Crotty, 1998), critical realists argue that, when taken to the extreme, if knowledge is seen as only socially constructed, then there can be no truth claims because truth becomes

relative to a particular individual or group (Clark et al., 2008; Wainwright, 1997). Although critical realists reject relativism, they endorse the importance of understanding meaning and the social context in which knowledge is developed; as such, knowledge is perspectival, open to questions and to change (Clark et al., 2008; Nairn, 2012). In drawing on the strengths of each paradigm, critical realists claim the middle ground between paradigms (Clark et al., 2008).

Throughout this section, I have pointed to a need to understand the contexts and conditions that contribute to moral distress, as well as to understand the meaning HCPs ascribe to these situations to gain greater insight into the idea of constraints. In order to answer my research question, I therefore sought a methodology that would be able to attend to the meaning and practical application simultaneously.

Toward an Ontology of Moral Distress.

As I have explained in this chapter, I used a critical realist approach for my study in order to move toward a definition of moral distress that could account for the complexity of the conditions that contribute to and influence the experience of moral distress. This required shifting from an epistemological focus on moral distress to an ontological perspective. That is, I wanted to shift perspective from an epistemological focus on developing knowledge *about* moral distress to an ontological perspective that focused on what moral distress must *be like*. This required moving beyond a descriptive focus on moral distress to understanding the experience as being emergent through interaction between, and among,

structures and agents. In what follows, I describe the features of critical realism that support the study of moral distress from the place of seeking to understand the phenomenon itself, rather than what can be known about the phenomenon at an empirical level.

Since Jameton identified the concept 30 years ago, nurse researchers have investigated the experience by trying to discern how we know an individual is experiencing moral distress. While this information can give us important insight into recognizing moral distress, it does not give us insight into what moral distress actually *is*. In critical realism, Bhaskar (1975) refers to this as an *epistemic fallacy*, which arises when what is known about a phenomenon is conflated with the entirety of the phenomenon (Angus & Clark, 2012). From empiricism, the epistemic fallacy is revealed in the assumption that what can be known about a phenomenon, and the causal mechanisms underlying the phenomenon, can be defined through the observation of fixed patterns.

If I were to apply this assumption to the concept of moral distress, in situations where there are external constraints, such as understaffing or policy initiatives that compromise a nurse's ability to provide care in the best interest of the patient, and the nurse is unable to act, I would expect nurses to exhibit symptoms of moral distress. However, this is not always the case, as other outcomes, such as moral disengagement, may occur (Rodney, Kadyschuk, et al., 2013). This dissertation research was based on the premise that we need to explore moral distress from an ontological position of speculating about what moral distress might *be*, rather than from an epistemological position of how we

can come to know the experience of moral distress (Bhaskar, 1975). It was also my premise that an ontological approach to understanding moral distress would enable researchers to theorize about the dynamic relationships between the external structures of health care delivery and the internal context of the moral agent. Thus, future researchers may be able to develop interventions that support health care providers to move toward taking action to support their moral obligations to the patient before the consequences of moral distress are seen at an empirical level.

In summary, as I have argued at the outset of this chapter, for this study, critical realism provided an ontological foundation that allowed a rich, nuanced, understanding of the conditions that contribute to moral distress, and critical realism provided a framework for theorizing about how the interaction between these conditions may result in moral distress. As a consequence of this study, it has been my intent that future researchers will be able to plan effective interventions in helping HCPs work through the experience. In moving toward an articulation of my methodology, I begin by examining the tenets and underpinnings of critical realism, including examples of how this approach may inform our understanding of moral distress.

Methodological Pluralism in Critical Realism

Theories developed using critical realism are based on generative mechanism(s) that underlie causation, and these mechanisms are often not easily amenable to direct study (Angus & Clark, 2012). As well, one of the

consequences of prioritizing ontology over epistemology, as Nairn (2012) claims, is that it offers “a route into a relational approach to knowledge that incorporates a pluralist approach to finding out about the world alongside a realist commitment to the structural properties of both the natural and the social worlds” (p. 7). This relational approach acknowledges the interplay between and among the biological, psychological, and social structural factors that influence outcomes in research (Nairn, 2012), and is consistent with my theoretical commitments in this research. In a health care context, acknowledging this interplay in research may more accurately reflect what takes place in the world, but it becomes difficult, if not impossible, for one research methodology to attend to this complexity.

McEvoy and Richards (2003) point out that in critical realism the primary concern is not the methods of investigation; rather, it is how these methods are used.

Generating Theory in Critical Realism.

The job of researchers using critical realism is to develop theories that can explain the causal mechanisms that lay at the real level of ontology beneath what is observed at the empirical level (McEvoy & Richards, 2003). These theories need to account for the conditions and contexts at the actual level of ontology that influence what may, or may not, be experienced at the empirical level (Wainwright, 1997). Wainwright identifies three keys for a realist explanation: “(1) the postulated mechanism must be capable of explaining the phenomena; (2) there must be good reason to believe its existence; and (3) there should be no equally good alternatives” (p. 1265). McEvoy and Richards (2003) describe theory development in critical realism as retrodution, a form of creative

reasoning. Retroduction involves observation and developing a theory to explain the observations. They liken the process of retroduction to that of detective work, whereby the detective solves a crime retrospectively by reading the signs that accompany the crime. Using the idea of retroduction and drawing on the concept of a stratified ontology, I will reach across disciplines and speculate about how the contexts and conditions discussed in the literature review may come together in a contingent way and lead to the experience of moral distress.

Given the emphasis on the contingent nature of reality in critical realism, developing theory requires seeking out variation in order to account adequately for the observed outcome(s) (Pawson & Tilley, 2004). GTM also encourages the researcher to seek out variation in order to develop a theory that can account for a wide range of experiences. I elaborate on GTMs in Chapter Four. In critical realism, by intentionally seeking out variation, the ensuing theory has greater capacity to explain how contexts, and under what conditions, generative mechanisms will be activated. Seeking out and examining variation in health care providers' experience of moral distress may help explain why certain situations lead to moral distress and others do not. Indeed, researchers using GT methodology seek out variation in the experience under study in order to account for the contexts and conditions that contribute to, or influence, the situation. Such has been my intent in this dissertation research.

It is important to note that GT is not the only methodology that is consistent with critical realism. Examples of approaches used for research from a critical realist perspective include using qualitative and quantitative methods such

as structured or semistructured interviews, participant observation, cluster analysis, GT and regression analysis (Clark et al., 2008; Cruickshank, 2012; Jantzen, 2012; McEvoy & Richards, 2003). As well, McEvoy and Richards state that critical realists have taken traditional methods of inquiry, such as a systematic review, and applied them in new ways. For example, Pawson (2002) provides an example of a systemic review using a critical realist approach wherein synthesis of data is based on “generative mechanisms” and its “contiguous context” (p. 342). Finally, from the field of social work, Blom and Morén (2011) have developed a model to assist researchers in identifying, describing, and conceptualizing generative mechanisms.

Although theorizing in critical realism provides opportunity for the development of a richer understanding of context and conditions that lead to moral distress, there are also critiques I needed to attend to in order to clarify my theoretical and methodological approaches in a credible way. In what follows, I discuss the critiques of theorizing in critical realism and include the addition of critical and relational inquiry lenses as a means of navigating these critiques.

Critiques of theorizing in critical realism.

Researchers in the social sciences have used a critical realist approach in order to explore complexity and to examine more process-oriented questions in their areas of study (Blom & Morén, 2011; McEvoy & Richards, 2003). More recently, researchers in nursing are being challenged to use critical realism to demonstrate the complexity that exists in developing effective health care policies, programs, and interventions in achieving positive outcomes, as well as

to conduct research for knowledge development in nursing (Bergen, Wells, & Owen, 2008; Clark et al., 2008; Littlejohn, 2003; McEvoy & Richards, 2003; Wainwright, 1997). To this end, nursing researchers have applied critical realism to research and theory development (Bergen et al., 2008; Littlejohn, 2003), policy reform/evaluation (McEvoy & Richards, 2003), theory-driven program evaluation (McEvoy & Richards, 2003; Pawson & Tilley, 2004), and improving knowledge translation, chronic disease management, and public health (Clark et al., 2008), to name a few areas.

As I have indicated in the preceding chapters of this dissertation, there has been a call by researchers to clarify the concepts underpinning the definition and experience of moral distress, and for the development of effective interventions. I assert that acknowledging the complexity of moral distress at the nexus between structure and agency is central to clarifying the underpinnings of moral distress. Critical realism offers an approach to both explore the relationship between structure and agency, and to theorize about this relationship. The focus of my research question was on the interaction between HCPs and the context in which they work. This focus on process went beyond a descriptive study to examine processes that are not directly observable. GT, with roots in symbolic interaction and pragmatism, has been well suited to the examination of process and theorizing about action. Critical realism and the belief in a stratified ontology allowed me to theorize about the complexity involved in the experience of moral distress. In Chapter Four, I elaborate on the use of GT as my methodology for this study.

As I have indicated throughout this chapter, applying a critical realist perspective to theory development in moral distress enabled me to move beyond examining moral distress at an empirical level to theorizing about underlying factors that contribute to the experience at the actual level of ontology. The resultant theory illuminates the contingent ways in which these factors come together. The potential for theory development in moral distress notwithstanding, it is important to note that several authors have expressed concerns about the nature of theorizing in critical realism. First, due to the ability of critical realism to allow the exploration of complexity, Angus and Clark (2012) pose the question: “how much complexity is too much complexity given the constraints of what is currently possible, feasible, and acceptable?” (p. 2). Second, these concerns have included recognition of the difficulty in identifying generative mechanisms (Angus & Clark, 2012; McEvoy & Richards, 2003). Finally, McEvoy and Richards (2003) note that there is potential for these theories to drift across scientific demarcations to political ideology. Given these concerns, it has been important to develop research strategies that support the identification of generative mechanisms, as well as the means to study these mechanisms (Angus & Clark; McEvoy & Richards). Also, in regards to the concerns about theorizing, the methods of GT are designed to help researchers develop a theory that arises out of the data. I explain these methods further in Chapter Four.

Summary of Implications for Moral Distress Research

My research question was directed toward conducting a critical examination of the concept of moral distress and the environment in which it occurs. Relational inquiry fostered an intentional consideration of how interpersonal and structural relationships may shape the research participant's ability to enact moral agency within the health care system. Taking up a critical and relational approach to this study reflected a belief in the capacity for change, and that change in either the agent or health care structures is an iterative process.

More specifically, framing the research process within a critical realist perspective guided me to move beyond a linear cause and effect explanation, to explore the layered, and complex factors that contribute to the experience. Exploring moral distress in a context that embraces complexity helped clarify how aspects of the health care environment interact with personal attributes of the individual to influence the experience of moral distress.

By embracing complexity and clarifying the underpinnings of moral distress, researchers have the opportunity to subsequently develop interventions that support reflective moral practice and positive health outcomes for HCPs and patients. Incorporating a critical perspective with relational inquiry in the research fostered an approach that extends the study beyond the individual health care provider to encompass the sociopolitical structures in which health care is delivered. The subsequent clarification of the attributes that contribute to

moral distress at both a structural and agent level facilitates the eventual development of intentional and multilevel interventions.

In summary, given my desire to eventually move toward practical interventions in moral distress that can be trialed within the health care system, I chose to use constructionist grounded theory to conduct this research. As I considered my research questions and the purpose of the research in order to make a decision regarding methodology, I recognized that I wanted a methodology that reflected

- attention to the process(es) that are present as individuals attempt to work through a situation;
- attention to the structural processes and conditions that influence the situation;
- attention to how the meaning attributed to the situation influences action;
- the ability to explain variation in the experience;
- the ability to provide an explanation for what is going on in the situation; and
- an explanation that could underpin a framework for interventions.

The purpose of GT research is the development of a theory that explains a pattern of behaviours or actions participants engage in to resolve a problematic situation (Glaser, 1978; Schreiber, 2001b). GT incorporates the elements listed above, and the resultant theory generated from this dissertation research will inform potential avenues for intervention. In the following chapter, I provide a background to the philosophical roots of GT, outline the grounded theory process

in developing a substantive theory, and describe my approaches for recruitment, data collection, and data analysis.

Chapter Four: Methodology

Choosing a research methodology is a reflection of both the research question and of the philosophical positioning of the researcher (Charmaz, 2011; Thorne, 2008). The question for this study centers on examining the processes HCPs working in mental health care engage in as they seek to enact their moral agency. I have studied these processes in a way that examines the reciprocity between structure and agency. The research question itself frames the particular interest a researcher has in a substantive area, and what is seen in the data that informs the findings. As such, the purpose of this chapter is to make the connection between my research questions and GTM. To accomplish my purpose, I outline my reasons for choosing grounded theory to answer the research questions. I do this by providing a brief reminder of the research problem, situating myself, along with the problem, within a constructionist paradigm, and then sketching out the history and context of grounded theory, along with the philosophical assumptions underpinning GTM. I then provide an overview of the methods and techniques and how they were used in this research.

Review of the Research Problem and Questions

As a starting point, I reviewed the introduction of moral distress to nursing literature, and the subsequent development of knowledge regarding the concept, ending with a critique of the concept and our current state of knowledge

regarding moral distress in Chapter Two. Although our understanding of moral distress has increased, a significant critique of the state of current knowledge on moral distress is that it lacks conceptual clarity. As I explained in Chapters One and Two, I have, therefore, taken up this challenge. I have drawn on research from across disciplines to create a conceptual framework for understanding moral distress as an embodied experience that is shaped by a reciprocal relationship between structures and agents. It is this reciprocal relationship that I intended to examine empirically through my dissertation work.

Framing moral distress in the context of the reciprocal relationship between structure and agency allowed me to attend to structures, both formal and informal, as well agents, in exploring how the environment interacts with the HCP to facilitate or constrain moral agency in the context of the provider's fiduciary responsibility to the patient. Based on my practice experience, I made an assumption that moral distress occurs in the context of balancing fiduciary responsibilities to patients within the current health care environment. From this perspective, I aimed to conduct a qualitative study to investigate the processes HCPs engage in, as they balance these responsibilities while navigating the reciprocity of structure and agency. The specific research question I intended to answer was:

How do HCPs in mental health care navigate morally charged situations and enact their moral agency within their health care organizations?

The research question reflects a desire to understand the processes HCPs engage in as they attempt to balance competing tensions between the needs of health care organizations and professional values. In addition, we know that the nature of the work in mental health care is process-oriented, and attends to factors in the environment that maintain, facilitate, or inhibit the development of protective factors and resiliency. Thus, the research methodology I chose for my study would have to also attend to context and process. In reviewing constructionism, SI, critical realism, critical inquiry, and relational inquiry in Chapter Three, I saw similarities in the assumptions underpinning these perspectives. Common to all of these perspectives is attentiveness to the relationship between structure and agency, and recognition that knowledge is constructed and situated in a historical, cultural, sociopolitical context (Agger, 1998; Crotty, 1998; Doane & Varcoe, 2013; MacDonald, 2001; Nairn, 2012). Because knowledge is constructed and situated, the meanings attributed to situations are multiple, allowing complexity, and variation. In the following section, I provide my rationale for situating this research within a constructionist paradigm and for my choice of GTM.

Situating Myself and the Research

As I indicated at the outset of this Dissertation, my journey toward becoming a researcher began as I struggled to reconcile what I have come to understand as the moral and ethical aspects of nursing with the reality of daily practice. In framing the research problem within the relational context of structure

and agency, the focus of my research was on the complex interplay of meaning, context, and process. I believed that a qualitative research approach is best suited to answer questions about complex processes. Aligning the ideas of relational ethics and moral obligations with research exploring meaning, context, and process, directed me to examine transformative research methodologies that explicitly recognize the partnership between the researcher and the participant, and that acknowledges context (Anderson, 1991; Freire, 2010). Consequently, I situated myself within a qualitative paradigm and took a constructionist position to explicitly foster collaboration between researcher and participant, because this reflects the complexity of the research question, while also laying a foundation for the later development of interventions. In stating that truth is constructed, my position is that our understanding of reality is influenced by the social structures in which we live. As well, in aligning with GTM, I aligned with the normative aspects of qualitative research and understood that facts and values cannot be fully separated (Charmaz, 2006, 2011; Jameton & Fowler, 1989). Consistent with the application of constructionism to the research question that I articulated in Chapter Three, I emphasized that actions cannot truly be understood outside of the context in which those actions occurred.

The purpose of this study was to develop depth in our understanding of how environmental and individual characteristics interact with and influence the experience of moral distress, as well as the factors that support or impede the HCP's ability to enact moral agency. This study can help clarify some of the constructs contained in the original definition of moral distress that, up until now,

have interfered with our ability to come to a collective understanding of the concept (McCarthy & Deady, 2008; Musto et al., 2015; Pauly et al., 2012). When I started out with this research, some of the constructs I had planned to explore included the role of taking action in the experience of moral distress, the embodied nature of the experience, and the interplay between the health care environment and the HCP that contributes to the perception of constraints and supports in the enactment of moral agency.

Given the need to clarify some of the constructs of moral distress, as well as to explore factors that influence the experience, I chose to examine the processes HCPs engage in when making ethical decisions and having to balance competing values. By adopting a critical realist approach, I recognized that the layered and contingent nature of reality required analysis of the underlying processes of moral decision-making and meaning-making. Examining these processes required that I explore, and try to understand, the meanings people, in this case HCPs, applied to an ethically challenging situation, and the role those meanings played, in order to understand the resulting action. GT is a research methodology that is focused on understanding social processes, and discovering the basic social process that lies at the center of action and brings about change (Glaser, 1978). It was also important that I examine the competing elements that influenced the context within which the HCP made decisions. As such, I determined that a qualitative approach was best suited to this research and that GT offered the requisite tools for the exploration of process and the understanding of meaning.

Origins and Evolution of Grounded Theory Methodology

Historical Background

In Chapter Three I outlined the theoretical approaches that framed this research and explained why I believed a constructionist position was best suited to answer my research questions. In this section, I provide a brief background for its development, and then trace the evolution of GT, eventually landing in a constructionist perspective. The historical context and epistemological debates within the discipline of sociology deeply influenced the explication and development of GT (Bryant & Charmaz, 2007a). In this section, I discuss these origins, beginning with a brief look at the historical context from which GT grew. I then review the academic traditions that Glaser and Strauss brought to the development of GT methodology; these traditions are positivism, SI, and pragmatism. Following a review of Glaser and Strauss, I discuss contemporary GT in the form of constructionist grounded theory and situational analysis. Finally, I provide a summary of grounded theory methods to develop theory from data.

The historical impetus for grounded theory. Barney Glaser and Anselm Strauss developed the grounded theory methodology in the 1960s, in part, as a response to the positivist culture that permeated the discipline of sociology. Glaser and Strauss first published their book, *Discovery of Grounded Theory* in 1967. Although they came from divergent philosophical backgrounds—Glaser from a positivist perspective and Strauss from a symbolic interactionist (SI) and pragmatist perspective—the purpose of their collaboration was to aid researchers

in the generation of theory (Glaser & Strauss, 1967). Glaser and Strauss expressed concern with what they saw as a focus on verification of existing theories, and the development of theories based on a-priori assumptions that were not grounded in the reality of what was actually happening in the situation (Bryant & Charmaz, 2007b; Glaser & Strauss, 1967). As a response to these shortcomings, they advocated for a shift in the focus of research away from verifying existing theory to that of generating new theory based on data. Thus, in *Discovery of Grounded Theory* the authors outlined the process involved in creating a theory that was rooted in the data, and exhorted sociologists to return to their primary mandate of developing sociological theory that was exciting and relevant (Charmaz, 2006; Glaser & Strauss).

Significant to the emergence of GTM is a recognition of the historical context in which Glaser and Strauss formed their partnership. As noted, Glaser and Strauss (1967) were responding to an emphasis on the need to verify theory in sociology. Verification of theory was a reflection of a belief in the supremacy of the positivist ideology inherent in quantitative research (Charmaz, 2006). In providing a coherent monograph that outlined the methods they used for the development of theory in their own research, Glaser and Strauss (1967) hoped to provide qualitative researchers with a systematic method for collecting and analyzing data in the process of generating theory. In doing so, they aimed to bring legitimacy to qualitative research. They also hoped to provide a rejoinder to critics who claimed that findings from qualitative research were not scientific enough for developing theory (Bryant & Charmaz, 2007a). Although Glaser and

Strauss created a research methodology that appeared to bridge the qualitative/quantitative divide, their philosophical origins eventually took them in separate directions and fostered an ongoing schism in GTM, leading to a variety of approaches (Milliken & Schreiber, 2012; Schreiber & Martin, 2013). In what follows I will provide an overview of that schism and justify my own commitment to a constructionist approach in this research.

Positivist grounded theory. Individually, Glaser and Strauss continued to use and develop grounded theory as a research methodology; however, each author applied GT in a way that reflected the tradition from which they came. Glaser says little about the philosophical roots of GTM (MacDonald, 2001), however, he is clear that GTM is a methodological approach that provides a systematic method for data collection and analysis, based on quantitative analytic methods (Charmaz, 2006; Stern & Covan, 2001). When Glaser (2006) does provide his view on the roots of GTM, he does not discuss the philosophical underpinnings; rather, he refers to the “four dimensions of doing sociology—autonomy, originality, contribution and the power of sociology” (p.1). In describing GTM methodology, Glaser states that, “GT is just a simple index formation, inductive method based on using any type of data” (p. 3). Even if the philosophical underpinnings are unstated, the initial and subsequent language used by Glaser to describe the process of doing GTM, and the development of a substantive theory, very much fall within a positivist tradition. Although others argue that GT falls with a post-positivist paradigm (Hall & Callery, 2001) Glaser’s writings convey a belief in an external reality that can be discovered, or

will emerge from, a careful analysis of the data (Bryant & Charmaz, 2007a). In refuting the idea of GTM as constructionist, he affirms that a researcher need not be concerned with concepts such as bias, because she or he is only identifying patterns that exist in the data (Glaser, 2002).

Social constructionist grounded theory. Strauss came out of an academic tradition that included symbolic interactionism (SI) and pragmatism. As a symbolic interactionist, Strauss emphasized the importance of understanding social processes as central to theory development. In attending to social processes, Strauss drew on SI and pragmatism (Strauss, 1995a, 1995b). SI is an approach that seeks to understand “human group life and human conduct” (Blumer, 1969, p. 1). The three core premises of SI identified by Blumer include: a) humans act toward things on the basis of the meaning things have for them; b) meaning arises out of social interaction; and c) meaning is handled in, and modified through, interpretive processes. While acknowledging the existence of an obdurate reality (Blumer, 1969), it is within the context of social interactions that meaning is constructed, and meaning can only be understood through direct examination of the social world. Blumer’s premises also make explicit the actor’s role as a thoughtful, conscious agent, actively making meaning, and choosing action in the social interaction, thus illuminating the reciprocity that exists between structure and agency pertinent to my research. In focusing on the need to understand meaning, and the context that shapes meaning, Strauss began to move GT away from positivism toward a constructionist paradigm.

Contemporary Grounded Theory

Constructionist grounded theory. As a student of Strauss, Charmaz (2006) moved GT further along the continuum of qualitative research. Within an interpretive paradigm, there exists a belief about knowledge production—in this case theorizing—as being situated within the context in which it is produced (Charmaz, 2006; Lincoln et al., 2011). Therefore, not only is the subject of the research contextually situated, but the knowledge produced through GT is also contextually constructed, and is influenced by historical, cultural, and social situations. Importantly, facts and values are seen as inseparable (Charmaz, 2006, 2011). What this means for theorizing is that the researcher is a co-creator of knowledge and an active participant in the development of the theory. In the context of values central to this dissertation, the values of the researcher directly influence what the researcher will attend to in the data. In taking the stance that the researcher is an active participant in the research, Charmaz effectively cuts the ties with positivist assumptions that the researcher is an objective bystander, who has no influence on the data or the emerging theory.

I used Charmaz's approach in GT for this research. Charmaz calls her approach *constructivist* grounded theory. Although Charmaz (2006) clearly locates constructivist GT within an interpretivist paradigm, she also claims that a constructivist view assumes an obdurate reality, acknowledging an ever-changing world with multiple and diverse realities. Thus, while cutting ties with the positivist underpinnings evident in early GT, Charmaz remains firmly

connected to the local context that shapes behaviour, meaning, and action. In my review of her method, I found it to align with my definition of *constructionist* as outlined in Chapter Three. As such, I consider Charmaz's approach to be constructionist and will refer to it as constructionist throughout this Dissertation.

Charmaz, along with Glaser and Strauss (1967), states that GTM can support the development of both substantive and formal theory, depending on the level of abstraction of the theory, meaning that GTM allows the exploration of how people's actions affect their local and larger world (Charmaz, 2006). This stance is relevant for my study, because one of my purposes is to examine the interplay between structures and agents, and an assumption I hold is that action at a local level can influence structure at a broader level.

Summary of GTM for This Study.

In developing GTM, Glaser and Strauss (1967) argued that the major task of sociologists was to develop a theory that fits the situation, is immediately understandable, and provides a relevant explanation. In order to accomplish this, Glaser and Strauss developed methods that supported researchers in data collection, coding, and theory development, so that the theory arose out of the data. The actual process of GTM research is comprised of common strategies, and includes: concurrent data collection and analysis; theoretical sampling to direct ongoing data collection and to elaborate categories; memoing of ideas, linkages between categories, and the tracking of research decisions; and diagramming. In using GTM to examine how HCPs navigate ethical situations in

the current health care climate, I developed a theory that is contextually relevant, and that sets the stage for future development of interventions that support the enactment of moral agency.

Conducting Grounded Theory

GTM helped me answer my research question centered on the enactment of moral agency within health care structures. There are strategies common to conducting all GT research that reflect its focus on processes, regardless of the ontological position of the researcher. I drew on these strategies for data collection, analysis, and theory building, to explore HCPs' enactment of moral agency. In this section, I outline the progression of my study, beginning with the inclusion and exclusion criteria for participants. I then discuss the concept of sampling in GTM. I provide a description of the participants, and my recruitment strategies. Following this, I discuss my methods of data collection and data analysis, which included memoing, constant comparison, and coding. Finally, I describe rigor for GT and how the resulting theory can be evaluated.

Inclusion criteria. The criteria for this study included HCPs from across mental health professional disciplines, such as social work, nursing, and occupational therapy. Participants could work at different levels of patient care—including providing direct patient care—or work at different levels of leadership. To try and understand how health care providers enact their moral agency within health care structures, I recruited participants who identify with the experience. To this end, I recruited HCPs who had worked in the health care system for a

minimum of six months, belonged to a regulatory body, and had an interest in discussing how they navigated ethically challenging situations in mental health care as evidenced by their agreement to participate in the study.

Exclusion criteria. There is some literature suggesting that moral distress is experienced by people working in health care that are not part of regulated professions. However, I am excluding unregulated providers from this research. Regulated professionals are held accountable to a professional Code of Ethics and Standards of Practice, and thus have an added layer to ethical decision-making. Literature in moral distress suggest that aspects of the experience may be related to health care professionals being unable to provide care according to their ethical obligations and Standards of Practice (Peter & Liaschenko, 2013); Thomas & McCullough, 2015).

Sampling

As I reviewed the different sampling strategies used in qualitative research in general, and GT in particular, it was apparent that the sampling process changes from an initial purposive sampling to theoretical sampling,²³ which is ongoing throughout the development of theory. For qualitative research, the principle guiding the selection of participants on initiation of the study is to seek participants according to the aims of the study (Coyne, 1997). Charmaz (2006)

²³ Purposive sampling refers to choosing a sample the researcher believes best fits the needs of the research, and as such, sample selection is not random (Polit & Beck, 2008), which is where GT begins. However, ongoing sampling is purposeful and attends to the theoretical concerns developing in the theory (Charmaz, 2006)

describes initial sampling in GT as the place to start in order to get relevant information for a study; as such, the researcher will want to identify ahead of time the group of people that will most likely be able to provide this information (Thorne, 2008). The criteria for selecting participants are established before the study begins and may include such things as age, gender, status, and role in the organization, or location (Coyne, 1997).

For my study, I began with purposive sampling, and initially recruited participants who self-identified as having experienced attempting to navigate ethically challenging situations in acute mental health care. As the study proceeded and data was analyzed, I used theoretical sampling to guide further data collection, which I describe in further depth in the next section.

Sensitizing concepts. A sensitizing concept is a concept the researcher brings in to research with himself or herself (Schreiber, 2001b). The current literature on moral distress provided some sensitizing concepts I used for direction with regard to participants and sources of data (Thorne, 2008). Research findings suggested that resource allocation, ambiguous policy, or lack of policy may be complicit in the experience of moral distress (Burston & Tuckett, 2013; Musto & Schreiber, 2012), and contribute to ethically challenging situations. A caution for the researcher that accompanies the idea of sensitizing concepts is that they may blind the researcher to other concepts in the data (Schreiber, 2001b). In the context of sampling and recruitment, I needed to take steps to remain open to what is in the data and not simply look for what I expected to find. I did this by making my own ideas and assumptions explicit

through memoing, a GT technique (Schreiber, 2001b). This caution speaks to the credibility of the research; I elaborate on strategies regarding rigor and credibility later on in this chapter.

Sample Size

In *Discovery of Grounded Theory* (1967), Glaser & Strauss claim that it is impossible to know beforehand how many participants will be required in order to achieve theoretical saturation and develop a theory that will answer the research questions. With this in mind, Charmaz (2006) and others suggest that the considerations for sample size also include the purpose of the study, the qualitative method being used, and the resources available to the researcher (Sandelowski, 1995; Thorne, 2008). I anticipated that 20 to 30 participants were needed in order to understand adequately how HCPs enacted moral agency in their particular context. By the end of the study, I had interviewed 27 participants.

Location

My study took place at two urban sites located in the lower mainland of British Columbia. The locations were chosen for several reasons: they each contain several inpatient acute care psychiatric units and have a large staffing pool. Moreover, I had access to potential key contact persons in both locations, either through personal connection, on the basis of my past professional work, or through members of my supervisory committee. Establishing connections within each site helped facilitate trust and credibility as I began the recruitment process.

Both sites were within a reasonable distance to me, either by car or transit, thereby keeping costs of the research at a manageable level. The use of two sites also provided a level of confidentiality for participants.

This study began once ethical approval was obtained at each these sites and at the University of British Columbia. I anticipated that one site (Site A) would be considered the primary site where most of the data collection would take place. The second location (Site B) would be used to enrich my observations, fill out developing categories, and elaborate the theory. In fact, recruitment and data collection occurred consecutively at each site, and data from both sites were used equally for theory development.

Gaining Access and Recruitment

Currently, in acute care psychiatry, care is delivered through a multidisciplinary team that draws on the disciplines of medicine, nursing, social work, psychology, and occupational therapy, to name a few. The sites I selected were in urban locations, had extensive inpatient mental health services, and employed a range of disciplines for the provision of treatment. Therefore, these sites afforded me access to a large contingent of staff across disciplines that provide care to diverse people with mental health challenges.

I received ethical approval for Site A approximately six months before I received ethical approval for Site B. Following ethical approval at Site A, I made initial contact with the leaders responsible for the mental health portfolio and explained the study over the phone. I was invited to attend a meeting with the

different managers of the various mental health programs within the organization and distributed written material about the study (Please see Appendix C “Letter of Introduction”). During this meeting, a key contact person was identified as a champion of the research to facilitate recruitment in the acute care program. The key contact made arrangements for me to attend the appropriate meetings to explain the study to staff, provide written information, and answer any questions. I also left written material at the site for staff not able to attend the meeting, and advertised for participants through site-specific media, and word of mouth. Several participants contacted me directly following these meetings to arrange an interview time. Other participants at Site A contacted me through word of mouth, requesting further information about the study, which I sent through email. If the participant expressed an interest in being interviewed, I followed up a maximum of two times to schedule an interview.

At Site B, I had an internal partner who organized a meeting with the administrator and leadership team of the mental health program to explain the process and purpose of the study. I left written material about the study and contact information with the leadership team. Similar to the process at Site A, my internal partner facilitated recruitment of participants by making arrangements for me to attend the appropriate unit meetings to explain the process and purpose of the study. Written material about the study and contact information was left at these meetings for people who were unable to attend. The internal partner also advertised the study through site-specific media and word of mouth. When an individual contacted me for information about the study, I provided written

material through email and followed up a maximum of two times to arrange an interview.

Data Sources

Data collection occurred consecutively across two acute care mental health sites over 15 months. Glaser (1978) coined the phrase, “All is data” in GT. Information gathered from interviews, focus groups, field notes, memos, observations, and textual information, such as historical, agency documents, or government documents, can all be included as data (Charmaz, 2006). Data sources for this study included participant observation, field notes, individual interviews, organizational vision and values statements, and government documents.

Participants

In GT, a researcher gathers data through a variety of sources, including people who have an experience of the phenomenon under study. For this study, I recruited HCPs who self-identify as having experienced ethically challenging situations in the delivery of care in a mental health setting. There is a small body of research indicating that moral distress occurs at different levels of the system and not just with front-line care providers (Mitton et al., 2011). I attempted to recruit participants from across professional disciplines that provide direct care to patients, as well as from middle and upper management who have responsibility for policy development and enactment, including resource allocation related to

mental health care. However, I was unable to interview anyone in senior management who had responsibility for resource allocation.

Description of participants. With the aid of a key informant at Site A and an internal partner at Site B, 27 participants from the disciplines of nursing, medicine, social work, and occupational therapy agreed to participate in the study. All 27 participants were interviewed, and three participants also agreed to being observed, resulting in 12 hours of data collection through observation. Most participants were reluctant to be observed, even though I had ethical approval, citing concerns about patient confidentiality and the expressed belief that they spend most of their time on the phone so I would have nothing to observe.

The participants worked in acute care mental health, either providing direct care to patients, or functioning in a leadership position. Most, but not all, participants in a leadership position occupied positions with a union designation of direct care (DC) or Educational Activities (ED) 2 or 3, and were considered part of the Leadership Team for the Mental Health Program. All the participants on the leadership team were nurses. One of the physicians involved in this study also held a clinical leadership position. Table 1 below includes a summary of the information related to the participants.

Table 1 Participant Characteristics

Total Number of Participants	Designations	Leadership Role	Direct Care	Average Age	Gender	Average Years in Position	Average Years in HC
27	20 RPN/RN 2 MDs 2 OTs 3 SWs	13 (+1 physician)	14 (including physicians)	43.6	19 F 8 M	6.1 years Range 1 month – 23 years	35 years Range: 1 – 40 years
Total Hours of Observation: 12 hours (3 participants)	3 RPN/RNS	1 Nurse in a leadership role	2 Nurses providing direct care				

Data Collection

Interviews. In-depth interviews are the most commonly used method for data collection in qualitative research (Charmaz, 2006; Nunkoosing, 2005; Thorne, 2008). Participant interviews took place at a time and location that was comfortable and convenient for the participant. The locations provided a certain level of privacy in order to maintain confidentiality of the participant and the information shared. Initial interviews were semistructured with open-ended questions based on my research questions. Almost all the interviews²⁴ were digitally recorded, and lasted between 45-75 minutes. Immediately following the interview, I found a quiet place and wrote a memo about the process and the content of the interview in order to capture salient reflections that resulted from the interview. A transcriptionist transcribed completed interviews verbatim, and then I listened to the interview and reviewed the transcript for accuracy. The

²⁴ Due to technical difficulties an interview was only partially recorded, while the recording for another interview was accidentally deleted from the digital recorder before it could be transcribed.

interview guide was adjusted as data were analyzed and core categories were developed (Please see Appendix D for the initial interview guide).

Participant observation. Participant observation is a strategy that can be used to facilitate rich data collection and analysis (Charmaz, 2006). Participant observation as a data collection tool refers to the researcher who is more or less active in the observer role, through questions and conversation, and may become involved in some of the activities specific to the environment because examining human action is central to developing a grounded theory (Charmaz, 2006; Chenitz & Swanson, 1986; Thorne, 2008). I engaged in participant observation in both of the chosen sites in order to observe the processes involved in decision-making regarding, for example, resource allocation, staffing decisions, and decisions related to patient care, because examining human action is central to developing a grounded theory (Charmaz, 2006; Glaser & Strauss, 1967). Observation of these decision-making processes informed my developing theory about how HCPs enact their moral agency within the current health care context. For example, during one period of observation, I witnessed a participant balance the demands of actual practice, and the expectations of colleagues who focused on efficiency. This observation helped saturate the subcategory of *living with bullying*.

To help gain entrance to the setting, and to build trust and credibility, I negotiated the level of my participation in unit activities with the unit manager prior to going on the unit. My participation was limited to activities that are supportive of staff, rather than direct patient care, for example, collecting supplies

for the participant (Thorne, 2008). Only a few participants agreed to being observed as they engaged in their job, and in these situations, participants only wanted me to accompany them for part of their shift. I engaged in four-hour observation periods with three participants. During the observation periods, I took field notes of the setting, the people present, and the process of the interactions among the people present in the setting. Immediately following the periods of observation, I wrote a memo to capture salient reflections.

A critique of participant interviews in moral psychology research, is the dichotomy that can exist between declared beliefs and values that underpin action, and what people actually do in a given situation, particularly in research that focuses on moral action (Greene, 2003). This critique is especially relevant to research in moral decision-making, indicating that people make moral decisions based on intuition rather than rationality (Greene, 2003). Given this critique, I intended to combine interviews with participant observations to help enhance our current understanding of the interplay between structures and agents in the experience of moral distress. However, participants did not want to combine the interview with the observation time, so the observations took place on a shift and at a time that was convenient for the participant, after the interviews had been conducted.

Participant observation was a valuable research method, but not without pitfalls. Bonner and Tolhurst (2002) have examined the advantages and disadvantages of participant observation from the perspectives of being an insider, from within the organization or discipline, and an outsider, from outside of

the organization. The authors identify advantages of being an insider related to already having established trust and intimate understanding of the group and group processes. Bonner and Tolhurst (2002) identify one of the primary disadvantages was the potential to overlook pertinent data due to familiarity with the participants and the setting. Both an advantage and a disadvantage to being an outsider was that the researcher is an unknown quantity to the participant or group (Bonner & Tolhurst, 2002). In this research, I was an outsider in all three periods of observation and did not have time to build up trust with those present in the environment, although several people were interested in what I was doing, and asked questions.

Document review. Although I did not enter into this research with expectations about what I would find in the data, my previous work in moral distress, and familiarity with the literature did provide some indication regarding individual and structural issues that may contribute to the experience. Burston and Tuckett (2013) provide a summary of the literature and identified the factors that contributed to moral distress. As discussed in Chapter Two, these factors included lack of access to resources that support the provision of care, including adequate staffing, and time, issues that raise conflict between team members, and constraining health care regulation or organizational policy. Awareness of these issues alerted me to further sources of data that shed light on the relationship between structure and moral agency. Further sources of data I reviewed included

- service plans for the Ministry of Health and Community Living British Columbia (CLBC);
- provincial policy frameworks related to mental health, e.g. *Improving Health Services for Individuals with Severe Addiction and Mental Illness* (MoH, 2013);
- provincial and national guidelines related to mental health and criminal justice, e.g. *Secure Rooms and Seclusion Standards and Guidelines* (MoH, 2012);
- strategic planning documents for mental health care delivery at the Health Authorities (HA) or provincial level, e.g. *MHSU Strategic and Operational Priorities, 2015-2020* (Fraser Health Authority, 2014); and
- organizational and unit vision and values statements, when available.

Data Analysis

Data analysis began as soon as I completed the first interview and continued until I finished writing up my findings. I used the tenets of GT, originally advanced by Glaser and Strauss, as a means of theory development, including concurrent data collection, and data analysis, constant comparison, memoing, and theoretical saturation.

Memoing. I used memoing to further develop conceptual categories and linkages between categories. Memoing is a flexible technique with the purpose of documenting ideas as they arise (Glaser, 1978; Schreiber, 2001b). The memoing process began before actual collection of data. I started writing memos early in the process to help identify what and how I might study moral distress. My

memos took different forms; for example some were written and at other times I recorded a voice memo. I also used mapping and drawing to try to work out relationships within the data, or as a means of visually clustering data (Charmaz, 2006; Schreiber, 2001b). Memo writing also served several purposes, including capturing ideas, making explicit, and reflecting on, assumptions, and tracking methodological decisions regarding the research (Schreiber, 2001).

Corbin and Strauss (1990) show that memos are not simply a way of keeping track of ideas; they are, in fact, related to the formulation of theory. I used memo writing to help form core categories and theoretical linkages that served as the foundation for theory. Throughout the process of analysis, I shared these memos with my supervisory committee members, who, in turn, helped me push my analysis further, and also clarify my thinking about the data. I continued to memo throughout the research, both to facilitate theory development and as a technique to foster reflexivity. I discuss reflexivity further in the discussion on rigor and evaluation of GT.

Coding. Much has been written about the process of coding and the development of a grounded theory by moving codes to increasing levels of abstraction (Schreiber, 2001b). Glaser (1978) identifies two types of codes in GTM: substantive codes that conceptualize what is going on in the data, and theoretical codes that conceptualize how the substantive codes may relate to one another. He also describes a process of generating codes and moving substantive coding to theoretical coding. Charmaz (2014) shows that coding includes at least two main phases, the first being an initial coding that involves

assigning a name or code to a word, line, or segment of data. This is followed by a more focused selective phase to help organize, sort, and synthesize large amounts of data. Although it appears that coding moves in a linear fashion from simple to more abstract, coding is an iterative process and coding at different levels of abstraction can occur simultaneously (Charmaz, 2006; Glaser, 1978; Schreiber, 2001b).

I began data analysis with line-by-line coding, a process by which I read through, and coded each line or phrase of data, linking these small units of data to a conceptual code (Glaser, 1978; Schreiber, 2001b). In this first phase of coding, I chose codes or words that closely followed the data. I used gerunds, or words ending in *ing*, as much as possible to help bring action and processes to the forefront (Charmaz, 2006; 2011). Fracturing the data and applying conceptual codes helped me recognize similarities and differences occurring in the data (Glaser, 1978; Schreiber, 2001b). For the first stage of data analysis, I created a code book in an Excel spreadsheet to keep track of the line-by-line codes. I conducted line-by-line coding on the first four interviews, resulting in 225 initial codes. As first level codes increased and I began to cluster similar codes together, I moved to writing the codes on 3 x 5 flash cards so I could make notes about the codes on the back of the cards, and I could maintain flexibility in creating focused codes. As I collapsed conceptual codes into focused codes, I compared them against incoming data. In creating focused codes that subsume lower level concepts, or second level coding (Schreiber, 2001b), I began to move the data to a higher level of abstraction in order to explain what was going on in

the incident. For example, the initial codes, *being an advocate, empowering patients, being patient centered, building collegial relationships, and using research to guide practice*, all became clustered under the focused code of *having a professional identity*.

Constant comparison. Data collection and analysis occurred concurrently using constant comparison. Constant comparison is a GT process that helps raise data analysis to higher levels of abstraction by comparing data to data, looking for similarities and differences (Charmaz, 2014). As new data came in, I compared it against developing concepts and categories; the developing categories were adjusted accordingly, and in this way the emerging theory remained grounded in the data (Glaser, 1978; Schreiber, 2001b). I used constant comparison to compare incoming data against existing codes, theorizing about possible relationships between codes. I made analytic decisions about what codes to develop into categories and what codes to put aside through this process. For example, after eight interviews at the first site, I began to formulate a hypothesis about enacting moral agency based on *affiliation with the team*.

As data analysis continued and I compared situation to situation, I analyzed variations in participants' affiliation with members of their team. This led me to examine the structure of teams in health care organizations, as well as the fact that participants often claimed affiliation to more than one team. In some cases, a participant identified both as part of a unit based team, as well as part of a disciplinary based team. As I read through the data I posed questions such as:

- What is actually happening in the data? (Glaser, 1978)

- What is this data a study of? (Glaser)
- What does the data suggest? Pronounce? (Charmaz)
- From whose point of view?

Theoretical coding occurred as I began to hypothesize about the potential relationships between categories, and to weave the fragmented data back together again into a coherent theory (Glaser, 1978; Charmaz, 2006). Theoretical codes are integrative and are intended to move the analytic story in a theoretical direction (Charmaz, 2006). To further develop the early categories of *affiliation with the team*, and moral agency, I theorized about the relationships between and among categories drawing on Glaser's coding family, the Six Cs: causes, contexts, conditions, contingencies, consequences, covariances, and conditions (Glaser, 1978, p. 74).

Theoretical sampling. Theoretical sampling is an intentional process researchers use to elaborate the emerging categories in order to develop a rich theory that can account for the variation of participants' experience (Charmaz, 2006; Glaser, 1978). Central to the idea of seeking out variation, and remaining grounded in the data is the ability to follow-up on concepts that emerge from ongoing analysis by seeking out participants able to elaborate on these concepts; in other words, theoretical sampling is used intentionally to develop categories (Charmaz, 2006). In this way the researcher can follow-up on questions, curiosities, and contradictions that arise, and ascertain whether or not they belong in the theory. As a theory began to emerge from data analysis, I used theoretical sampling to elaborate the categories.

An example of theoretical sampling in this study emerged as participants described barriers or constraints on enacting moral agency and navigating some of the ethical challenges that resulted from lack of resources or ambiguous policy. Participants identified that one of the barriers included working on a team with a colleague who was a bully, making it difficult to negotiate further resources or to seek clarification of policy. Thus, I used theoretical sampling and sought out participants who worked in situations in which the ethical challenges involved working with a colleague who was a bully. The result was that the focused code of *affiliation with the team* became subsumed under the category of *Working through Team Relationships*. I developed the category, *Struggling with Inhumanity* that contained subcategories to account for the range in variation of behaviour that resulted when participants worked on a team with a colleague who was a bully.

Schreiber and Martin (2013) remind us that the role of the researcher in constructionist GTM is to move beyond the participants' interpretation of "what is happening" to "create his or her own explanation." In constructionist grounded theory, it is the process of coding and increasing levels of abstraction, or fracturing the data, and weaving it back together, that moves the researcher beyond the individual participant to construct a collective understanding of what might be happening. The process of moving back and forth between substantive and theoretical codes kept the emerging theory grounded in the data and provided directions for theoretical sampling.

Rigor and Evaluation of the Resulting Grounded Theory

The notion of rigor in qualitative research has been contested as a concept that is not always seen as applicable to research conducted from a constructionist ontology (Chiovitti & Piran, 2003; Hall & Callery, 2001; Sandelowski, 1993). Regardless, criteria for evaluating qualitative research, as well as suggestions for increasing rigor in GTM, exist (Charmaz, 2006; Chiovitti & Piran, 2003; Hall & Callery, 2001). Glaser and Strauss (1967) originally identified *fit*, *work*, *grab*, and *modifiability* as requirements of GT. They defined *fit* to mean that the “categories must be readily (not forcibly) applicable to and indicated by the data under study,” and *work* meant that the theory must be “meaningfully relevant to and be able to explain the behaviour under study” (1967, p.3). Glaser (1978) later added *relevance* and *modifiability* stating that the theory must be relevant to the action and that a grounded theory must be modifiable to accommodate the addition of new data. Glaser maintained that if a grounded theory had fit, work, and relevance, it would have *grab* and become immediately recognizable to anyone familiar with the phenomenon, and consequently, the theory would be interesting to the reader and actually be used (Glaser, 1978). At different stages of analysis and theory development, I shared the emerging theory with participants or other HCPs working in acute mental health care to ensure my analysis reflected the experience of those working in the field.

Along with fit and work, Glaser and Strauss believed that rigor and the criteria for judging a GT should be based on the actual strategies used for conducting a GT, including purposive and theoretical sampling, concurrent data collection and analysis, constant comparison, and memoing. As well, theoretical sampling should include seeking out variation in order to elaborate fully the properties of the categories.

As noted above, subsequent researchers have offered suggestions for increasing rigor in GT beyond those offered by Glaser and Strauss. Charmaz (2006) suggests that criteria for evaluating constructionist GT include credibility, originality, resonance, and usefulness. The criteria suggested by Charmaz capture Glaser and Strauss's criteria of fit and work, and provide questions that researchers could reflect on as they consider their desire to produce a scholarly product. Although Glaser and Strauss emphasized adherence to the processes involved in conducting a GT, the questions posed by Charmaz inherently encourage the researcher to consider decisions made about the process. Central to both qualitative research and constructionist GT is acknowledging the influence of the researcher on the research process, and making that influence explicit.

Reflexivity. Toward this end, several grounded theorists have encouraged the inclusion of reflexivity in the research process in order to enhance rigor (Charmaz, 2006; Gentles et al., 2014; Hall & Callery, 2001). Reflexivity involves researchers in critically reflecting on how they influence the research process (Hall & Callery, 2001; Reay, 1996). Hall

and Callery, as well as Mruck and Mey (2007) offer examples of how conscious and unconscious processes influence the decision-making of the researcher. Common in all the discussions on increasing rigor and assessing the credibility of a constructionist GT is the admonition that researchers offer an accounting of decision-making related to the research process, so that the reader can ultimately make a decision about the credibility of the study (Charmaz, 2006; Glaser & Strauss, 1967; Hall & Callery, 2001).

To make the evolution of this research process explicit, I kept a journal on my personal reflections of interviews, observations of the data, and how different readings influenced my thinking about the data. I dated all memos and drawings. I met regularly with my supervisor and methodology expert to discuss data analysis. During these meetings, my committee members would ask probing questions about my analysis to help make my assumptions and biases explicit. At several points in the process I wrote up a summary of the developing theory and shared this summary with my committee. I also dated adjustments to the interview guide as needed.

Schreiber (2001b) identified the goal of grounded theory research as, “the construction of a parsimonious theory with concepts lined together in explanatory relationships that, in accounting for the variation in the data, explains how participants resolve their basic social problem” (p.78). In an effort to align my goal for the outcome of this study to the end goal of a

grounded theory, my committee included an expert in GT. During this research process, I shared the ongoing process of data analysis with my committee members. I met regularly with committee members to discuss the emerging analysis. I also received feedback on long memos and diagrams of the emerging theory and discussed changes to the interview guide, and strategies for theoretical sampling as the theory developed.

As well, I attended and received mentorship and support from members of the Grounded Theory Club (GTC), an advanced qualitative research seminar Based at the University of Victoria, which meets on a bimonthly basis, as the research progressed. The GTC is a space where the research process is shared with others who have various levels of experience in conducting grounded theory research. These discussions provided direction for theoretical sampling, and identified potential emergent fit in other substantive areas. The dialogue itself helped to deepen my understanding of the data and recognize how my individual perspectives influenced my understanding of the data (Schreiber, 2001a). The GTC also became a place where the ideas of *fit* and *work*, could be assessed as the theory developed. For example, at one meeting, members of the GTC probed my thinking on the basic social process, which helped to solidify my analysis.

To further establish the credibility of the developing theory, I selectively shared the emerging theory with participants and those who had knowledge of ethical decision-making in acute care mental health

settings to assess for grab and relevance. This process added depth to my analysis as participants sometimes challenged my ideas; other times participants took the developing theory and immediately applied it to and ethical challenge they experienced.

Ethical Considerations

I obtained ethical approval for this study initially through the Human Ethics Review process at the University of British Columbia (UBC). Following ethical approval through UBC, I received approval from the two local HAs involved in the study.

Informed Consent

Informed consent in this research meant that participation was voluntary, was considered an ongoing process, and could be withdrawn at any time. Participants were given full information about the research prior to participation, including the purpose, procedure, requirements, and the risks and benefits of participating in the research. Although the risks associated with participating in the study were deemed as minimal, as is common with most qualitative research that relies on interviews as the primary sources of data, it was difficult to know ahead of time where the inquiry could lead (Thorne, 2008). As well, to achieve the purpose of this research—gaining insight into how HCPs enact moral agency in their current health care environment—I asked participants to discuss situations that centered on their values. At their best, values-based discussions related to clinical situations, if conducted in a way that is helpful, may help

participants explore their actions in relation to their personal and professional values and potentially help participants clarify how they will respond to ethical situations in the future (Musto & Schreiber, 2012; Webster & Baylis, 2000). Values-based discussions, if not handled well, can also lead to increasing the experience of moral distress (Musto & Schreiber, 2012). Regardless of how well the conversation is facilitated, there is the potential that a participant will be emotionally triggered by the discussion. In drawing on writing from Thorne (2008), to honor the intention of ongoing consent, I occasionally checked in with the participant and provided an opportunity for the participant to decide if he or she wished to continue with the process.

As per the suggestion from Munhall (2007), after the participant had agreed to be part of this study, I provided written information regarding the purpose of this research, the time commitment, the potential risks connected with the research and the consent forms. The risk of harm that could result from participation in this study was deemed minimal by the research ethics review boards that authorized the study. Nonetheless, strategies I planned to use if a participant expressed a serious emotional response included: pausing the interview to create time for the participant to reflect and decide if she or he wished to continue; discussing supports or strategies the participant normally used to help manage emotional distress; and providing information about external supports the participant could access, for example the Employee Assistance Program, if needed. It was not necessary to use any of these

strategies, and no participant expressed a serious emotional response due to participating in this study.

A consideration related to informed consent is that of secondary participants. When engaged in participant observation, this would inevitably include people, such as patients, family members of the patients, or other members of the health care team who had not directly consented to being involved in the research. In these situations, I introduced myself, and supplied written information about the study, explaining the purpose of my presence and requested verbal consent. If the secondary participant declined verbal consent, I exited the interaction.

A final aspect of informed consent discussed with participants, also relevant to confidentiality, related to my professional Code of Ethics as a nurse. Although I stepped into the field as a researcher, I was (and am) governed by my professional Code of Ethics; consequently, if during the course of participant observation I saw something that was likely to result in harm to a patient or a staff member, I would have been obligated to report the incident through pre-negotiated health authority channels (e.g. to a charge nurse). No such incidents happened during an interview or observation.

Confidentiality

Another ethical consideration was that of confidentiality. Although I sought research participants from two separate HAs, the mental health community is small and interconnected; therefore, confidentiality could become an issue, in particular for those higher up in management with decision-making authority.

Participants in the study are identified by pseudonyms, the level at which participants deliver services are identified as “direct care,” “leadership team,” and “senior” management. As previously noted, using two sites for data collection, each in a different health authority, helped obscure the identities of the participants and the sites. Interviews were conducted in private, at a place of the participant’s choice, so as to protect the identity of the participant.

Researcher-Participant Relationship

In constructionist GT, the relationship between the participant and the researcher is viewed as part of the research process and is treated as such (Charmaz, 2006; Thorne, 2008). This treatment has ramifications for both the development of knowledge and for ethical considerations. The researcher and participant are considered co-creators of knowledge; this standpoint incorporates the belief that the researcher does not stand apart from the research as an objective bystander. Rather, the researcher is a part of the process, along with the participant, of trying to make sense of the phenomenon under study (Charmaz, 2006, 2011; Kahn & Eide, 2008).

From a constructionist stance, I viewed the research process as a relational process requiring the same ethical considerations given to any relationship in which there may be a real or perceived power imbalance. I held no position in the HA; therefore, I was not in a power-over position with any potential participants. This being said, the mental health community is small and I have held various positions in health care, at a local educational institution that prepares psychiatric nurses, and with the regulatory body for Registered

Psychiatric Nurses. In order to alleviate any perceived power imbalance at the selected sites, I was transparent regarding the research and the research process. All participation was voluntary, and for any observations done that include interaction between the participant and a patient, I obtained verbal consent from the patient.

Dissemination of Findings

Knowledge translation (KT) refers to the processes used to describe the movement of knowledge developed through research into clinical practice. The Canadian Institutes of Health Research (2015) has identified two broad categories of KT, integrated KT (iKT) and end-of-grant KT. Integrated KT is an process whereby knowledge users are involved in all stages of the research project in the co-production of knowledge that is relevant to their practice and context (Kothari & Wathen, 2013). End-of-grant KT refers to communication activities that researchers engage in to make potential knowledge users aware of the information that resulted from the project. Canadian Institutes of Health Research (2015) identifies these activities as diffusion, dissemination, and application, and defines each of these activities according to the degree the researcher customizes the information directed at the target audience. Diffusion of knowledge requires little customization of information; dissemination of knowledge is more tailored and the language is adapted to the target audience; finally, application of knowledge is further customized so that the target audience can use the information in a practical way.

As doctoral studies are intended to develop independent research skills, I conducted this study independently, under the supervision of my committee, without incorporating knowledge users as partners in the process. As such, I chose activities that fell into the category of end-of-grant KT activities, diffusion and dissemination. Diffusion activities, intended to get the findings from this research out to academics working in bioethics and mental health, will include publication of articles in academic journals and presentations of the findings at local, national, and international conferences professional conferences.

One of my goals for this research is to use the findings to inform health care delivery at the meso, macro, and micro levels of acute care mental health settings. Towards this end, at the meso level, dissemination of the findings will include writing an executive summary, tailoring the language to legislative policy makers to support policy directives. I will also offer to present the findings, and implications, to the regulatory bodies, to be used for position statements. To influence policy development at the macro level of health care delivery, the language of the executive summary will be adjusted to reflect concerns of health care directors and managers in acute care mental health. I will also seek to present the finding in face-to-face meetings with the directors and managers at the organizations that participated in the study. Where possible, in collaboration with the internal partner at each site, we will present the findings at organizational research events. Further, at the micro level to disseminate the findings to the participants in this study, I planned strategies with them for sharing the information that best suits their needs.

Chapter 5 Findings

In the previous chapters, I have made the argument that moral agency cannot be understood outside of the structures that influence action. I have also argued that GTM provided the means to explore the process and meaning of the actions taken by participants to navigate morally charged situations at the intersection of structure and agency. Below, I present the findings of this research directed at developing a substantive theory of how HCPs enact moral agency within the acute mental health care system.

This model, *Risking Vulnerability: Enacting Moral Agency in the Is/Ought Gap*, captures the immediate context that influenced participants' actions, such as the unit or program in which the participant was situated. As well, in the model, I describe broader societal elements that affect acute care mental health, such as changes participants noted from outside government ministries. *Risking vulnerability* involved three categories: *working through team relationships*, *struggling with inhumanity*, and *pushing back*. Many of the participants relayed more than one ethically challenging situation and described experiencing greater or fewer constraints on moral agency, depending on contextual elements, like who was involved, the nature of the situation, and available supports or resources within the agency. As such, navigating ethical challenges was not a linear trajectory. The model is intended to reflect the convergence of what the participant brought to the situation, with the immediate context situated in a

particular moment in time. This meant that the participant could have experiences of more than one category within the organization.

Figure 1 Risking Vulnerability: Categories of Action

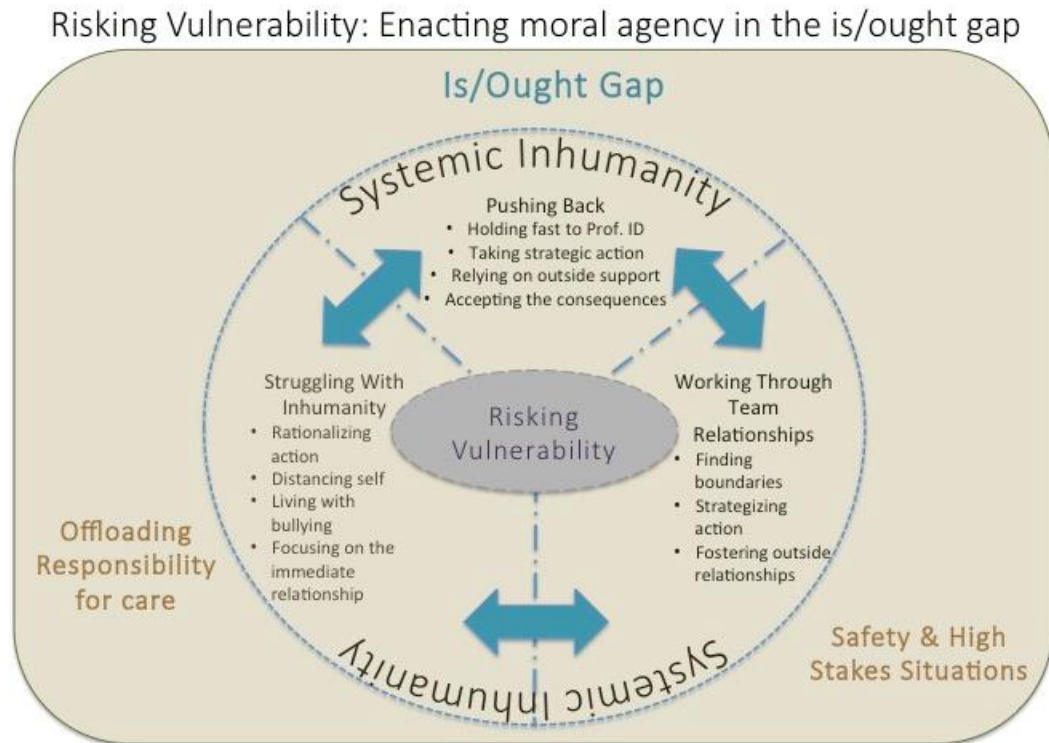


Figure 5.1 – Model of Categories of Action

Context of the Study

The concept of the is/ought gap that frames the context of this study was drawn from the discipline of philosophy. The premise of the is/ought gap²⁵, also referred to as the fact–value split, is that it is not logically possible to make an evaluative (values) statement based on descriptive elements (facts) alone. The fact–value distinction is about analytic thinking and bridging the divide between facts and values. A closely related philosophical concept to the is/ought gap is the *naturalistic fallacy*, or the tendency to make an assumption about how things *ought* to be based on the way things *are*. Both concepts have a long history of discussion in philosophy and reflect potential flaws in ethical thinking that can occur as people attempt to reconcile values with actions (Blackburn, 2016; De Vries & Gordijn, 2009).

In framing the background of this study within the philosophical concept of the is/ought gap, I am highlighting the core ethical struggle confronting participants who were attempting to reconcile the values-based nature of their health care professional practice with the limitations of the health care system. The fact–value split was reflected in the gap between values-based claims from

²⁵ The is-ought problem in philosophy refers to Hume's law, where he states that it is impossible to derive an "ought" statement from an "is" statement by logic alone (Blackburn, 2016; De Vries & Gordijn, 2009). Many of the ethical challenges participants described in this study reflected their struggle to try and reconcile the facts of health care service delivery with the values of their profession. An example of the *naturalistic fallacy* from this study is that just because there *are* limited community services for people struggling with mental health issues (a fact), does not mean that there *ought* to be limited community services for people struggling with mental health issues (a value).

government ministries and health care organizations about the quality of care provided in the health care system (the “ought”), and the quality of care and services that, participants indicated in their accounts, are actually provided (the “is”).

I conducted this research across two different urban sites in Western Canada. The focus of the study was the enactment of moral agency when HCPs, working in acute mental health care programs situated in general hospitals, confronted ethically challenging situations. I interviewed 27 participants²⁶ from across disciplines. Interviews included participants who delivered direct care to patients, as well as participants who worked in leadership and middle management positions in the mental health programs. The ethical challenges that participants talked about occurred in this gap and were often related to insufficient resources and space for mental health patients, along with the acute care system being used as a fill-in measure for other ministries that do not take up responsibility for patient populations that actually fall within their mandate. Participants worked in the space and recognized this gap between the care that ought to be provided and the care that is provided. However, most saw the problems as a result of bigger systemic issues that they could not change. This meant that most participants were resigned to working in less than optimal

²⁶ To preserve the anonymity of the participants, I have assigned pseudonyms and obscured personal details such as gender. I have also altered some of the quotes to preserve the intent of the participant’s message, but, at the same time, conceal potentially identifying speech patterns.

circumstances and providing less than optimal care. At the same time, participants struggled to continue to act as moral agents in ethically challenging situations in an effort to mitigate the impact of the is/ought gap on patients. They measured their actions against their professional identity²⁷ and the moral obligations of their profession.

The stories participants recounted about ethical challenges took different forms and included regularly occurring situations, such as experiencing an increase in the admission of two complex patient groups, patients with a dual diagnosis²⁸ or a forensic history, to the acute mental health care system. Some of the situations described by the participants extended over weeks and sometimes even months, and included employee performance issues, or circumstances that required resources that extended beyond the acute care system to resolve, such as long-term treatment and housing issues for vulnerable patients.

²⁷ Professional identity in this study referred to the way participants self-identified as being a member of a particular professional group, specifically nurses, social workers, psychiatrists and occupational therapists. As participants shared stories about ethical challenges they faced in practice, they conveyed the sense of professional expectations that came with being part of a professional group. Although participants did not explicitly talk about professional identity, they drew on their professional and disciplinary knowledge, skills, values, and competencies to describe their responses to these situations. The concept of professional identity will be discussed further in Chapter Six, the discussion chapter.

²⁸ Dual diagnosis refers to individuals with a developmental delay and a mental health diagnosis (Byrne, Hurley, & James, 2007), and the forensic population refers to people who have a mental health diagnosis and a history with the criminal justice system.

Offloading responsibility for care is part of the background context of this study. Offloading responsibility for care occurred between disciplines, hospital departments, and units, as well as between hierarchical levels of the health care organization. One of the consequences of government agencies offloading responsibility of care was that the acute care mental health programs took up responsibility for these complex patients. The result was that participants noted a rise in the admission of two specific population groups into acute care psychiatric units: patients with a dual diagnosis and patients with a forensic history.

One of the mechanisms by which some government ministries commonly offloaded responsibility for a person with a developmental delay, or by which someone from the forensic system was declined, or refused services, was that patient's mental health diagnosis. At a governmental ministry level, this meant that for someone who needed forensic or CLBC services, and also had a mental health (MH) diagnosis (or could be given one), CLBC or the forensic system took the position that providing services for that person was the responsibility of MH. Because of this, some of these patients, in order to have their basic housing and health needs met, came to be seen as frequent "users" of the acute care sector.

Offloading responsibility for care also occurred between departments in the hospital. At an organizational level in the acute health care programs, several participants reported that if a patient with a mental health diagnosis was in the hospital for medical issues, the medical team would push to have the patient transferred to the MH units regardless of the patient's presenting needs. This

meant that medical patients with mental health issues were at risk of increased morbidity in the psychiatric areas because their medical needs could not be adequately met due to lack of medical equipment or specialized medical knowledge.

Safety and high-stakes situations permeated the background context of this study. I use the phrase, safety and high-stakes situations, to refer to the increased levels of risk for significant harm, or aggression, including death. The rising risk for harm to both HCPs and patients related to the two population groups that participants stated are seen with increasing frequency in acute MH. Participants spoke about how the increased frequency and intensity of violence from the forensic population being cared for in acute care MH placed staff and other patients at risk for significant harm. Participants also talked about having more patients with a dual diagnosis being brought into hospital by police because the patient had been found on the street close to death. Police would report that these patients had concurrent drug issues and were being exploited, sexually and physically, on the streets. The police would request that the patient be kept in hospital until safe housing could be found, because they believed that if this did not happen, the patient would die on the streets.

Overcrowding in high acuity areas, such as the ED, combined with a push for the efficient flow-through of patients, also contributed to increased risk for aggression directed at staff, as well as deterioration of patients. Several participants who worked in the ED described ambiguity surrounding having a cap on how many patients they could accept into the area designated for mental

health patients. According to the participants, an area designed to accommodate 13–14 patients regularly housed nearly double that number. This occurred because there was no official cap on how many patients could be in the area, and staff understood they were not allowed to refuse to bring patients into the area even when the area was overcapacity.

In the high acuity inpatient units, participants also attributed increased safety risks to overcrowding on the unit and having to move patients through their services quickly. One participant described the doubling of patient admissions and discharges over a one-year span, stating that staff felt like they were being told to “dance faster.” The increased patient flow-through was accomplished by decreasing the patient length of stay. As well, putting patient beds in areas that had previously been used by patients for watching TV or sitting quietly also increased patient flow-through. The combination of overcrowding, increased flow-through of patients, and the mix of volatile patients with vulnerable patients resulted in increased risk to safety and for significant harm to both HCPs and patients, significantly altering the quality of the environment for patient care overall.

Systemic Inhumanity

In GT, the basic social problem is often an unarticulated issue or concern that participants share (Glaser, 1978). In this study, the basic social problem participants were attempting to navigate was the *systemic inhumanity* that was built into the acute care mental health programs. During data analysis, I struggled

to come up with a word or words to describe what I was seeing in the data.

Several of the participants spoke about small acts by the organization, or carried out by HCPs, that they viewed as a “humanizing thing,” which led me to examine the idea of delivering *humane* care. The *Online Etymological Dictionary* defines humane as follows:

Human and humane were used interchangeably in the senses "pertaining to a human being" and "having qualities befitting human beings" (c. 1500). The latter at first meant "courteous, friendly, civil, obliging," then "marked by tenderness, compassion, and a disposition to kindly treat others" (c. 1600). By early 18c. the words had differentiated in spelling and accent and humane took the "kind" sense.

This definition of humane aligns with my understanding of the values that are supposed to underpin healthcare and the discourse of care for vulnerable people. Treating others, patients and colleagues, with “respect” and “compassion,” and “dignity” are explicitly stated values in the professional Standard of Practice and Code of Ethics across the health care professions (e.g. Canadian Medical Association, British Columbia College Social Workers). The opposite, inhumane, means "destitute of human qualities."²⁹ In the context of this dissertation, I use the word humane to reflect the delivery of care that extends courtesy, respect,

²⁹ The concept of humane practice is implicit in the various professional Codes of Ethics, rather than explicitly stated. I address the concept of humane care in more depth in Chapter Six, the discussion chapter. In this chapter, to provide context for humane care, I drew on the dictionary definition cited above.

<http://www.dictionary.com/browse/inhumane?s=t>.

dignity, and compassion toward those engaged in and with the system. The word inhumane reflects the opposite and was corroborated to varying degrees when participants used words or phrases such as “lack of respect,” “lack of compassion,” “a need to advocate for patients,” and “a need to treat others like human beings,” as they described the different situations. Taken together, the ethical challenges participants portrayed resulted from a systemic responses embedded within health care organizations; responses that largely impeded their ability to extend a basic level of respect, compassion, and dignity to many of the patients who came into contact with the mental health care system.

According to participants, *systemic inhumanity* is what people labeled with a mental health diagnosis frequently encountered when they entered the acute care system. At different levels of the health care system, participants provided examples of how the system was unable to respond consistently to mental health patients with respect, kindness, compassion, and dignity. Participants regularly explained that an inhumane response to MH patients was built into acute care policies and practices. The pervasive nature of the disrespect and indifference to the consequences of inhumane care extended specifically to this population contributed to some participants’ inability to recognize ethical issues, such as

inappropriate use of the security room (SR).³⁰ At the same time, it added to others feeling that they would not be able to influence positive change in the system. In a similar way, participants also provided examples of how bullying of patients and colleagues was rationalized and tolerated within the health care system. I will take up the topic of bullying in Chapter Six, the discussion chapter.

Risking Vulnerability

The basic social process (BSP) in GT is the process by which participants attempt to navigate the basic social problem, and can account for variation in patterns of behaviour (Glaser, 1978; Morse, 2001). As discussed above, *systemic inhumanity* was the basic social problem that participants were attempting to navigate. The ethical issues that participants described, and that exposed systemic inhumanity, were varied and included using the Mental Health

³⁰ The following definition of a security room is based on the Province of British Columbia, Ministry of Health Report, *Secure rooms and seclusion standards and guidelines*, 2012): "Seclusion is a physical intervention used when a person is considered to be in a psychiatric crisis. This person is put into a room or space from which they cannot exit" (p.1). In this research, a secure room exclusively refers to the room used for a seclusion intervention.

Act (MHA)³¹ to restrict a patient's movements so they could not leave the hospital unit or grounds, after he or she no longer met the criteria for certification. As well, participants described struggling with issues related to role clarity and who was responsible for responding to the unsafe practice of staff or dealing with staff conflict and lack of professionalism. Together, these accounts pointed to diverse and ongoing ethical challenges for patient care and health care providers' well-being.

More specifically, ethical challenges included a disregard for patient rights, such as inappropriately sharing confidential patient information across government agencies without patient consent, or the negative manner in which patients seeking medical care were treated as they entered the ED. Examples of systemic inhumanity were seen in the physical environment that housed the acute mental health programs. The environment included overcrowding and frequent moves of psychiatrically fragile patients around the ED (often destabilizing them) because there was no available bed in an inpatient

³¹ A common account through this research was the use of the Mental Health Act (MHA) to make patients *involuntary* using section 21 of the MHA so that the patient could be brought back to hospital under a police warrant if they left without permission. The MHA applies to patients with a mental health diagnosis and is used to keep a patient and the public safe from harm. During the course of this research, several participants shared instances where the central ethical issue was that a patient was being held in the hospital under Section 21 when they no longer fit the criteria for being a safety risk or did not actually have a mental health diagnosis. In all these stories, the ethical struggle around the inappropriate use of the MHA resulted from a lack safe or appropriate housing to discharge a vulnerable patient. Specific to these stories was the belief that if the patient was discharged without appropriate housing, the risk of death or harm was high.

psychiatric unit. Other examples included maintaining patients for extended periods of time in the SR due to inadequate physical and systemic resources. This included putting patient food directly on the floor of the SR because if food was served on a paper towel or cardboard tray, the patient might use it to plug the toilet.

Overall, unsafe conditions for staff and patients related to an increase in violent offenders being cared for in the acute mental health care system. Participants responded to these ethical challenges by taking actions at the micro or meso level of the health care system to attempt to interject kindness, respect, and compassion into the experience of the mental health patient.

In this study, the BSP, *risking vulnerability*, refers to the behaviour participants engaged in as they enacted their moral agency and attempted to maintain an ethical practice amidst systemic inhumanity in the acute care health care system. In other words, *risking vulnerability* referred to how participants navigated the is/ought gap. Risking can be defined as “exposing oneself to injury or loss; hazard,” (Oxford University Press, 1998, p. 708) and vulnerability has been defined as “the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally” (Oxford University Press, 1998, p. 935). In this study, participants struggled to enact their moral agency by holding knowledge of their professional obligations, clinical expertise, and organizational processes in tension with their own vulnerability in the system, as they made choices about what actions to take while navigating ethical challenges. When participants risk vulnerability, they expose themselves

emotionally and professionally to the risk of losing their job/position, having their professional reputation called into question (publically), and potentially losing credibility with peers, thereby resulting in exclusion from that team. Thus participants risked vulnerability, to one degree or another, depending on the context of their immediate work environment.

The research question I set out to answer in this study was: *how do HCPs in mental health navigate morally charged situations and enact their moral agency within their health care organizations?* It is important to note that all participants enacted their moral agency to varying degrees with differing levels of success; many participants acknowledged they were not able to achieve their moral end goal to the extent they wanted. Below, I explain, and elaborate on the categories that make up this theory. I also want to point out that only one of the categories, *pushing back*, was directed at actually changing the status quo at a broader unit or system level. By this, I mean that in the category of *pushing back*, participants attempted to hold others working in the system accountable to explicit organizational or system values, such as caring for vulnerable patients and providing patient-centered care. In the categories of *struggling with inhumanity* and *working through team relationships*, participants directed their actions toward trying to be ethical practitioners in the immediate situation. In these two categories, creating broader system change was viewed as either not possible, or was not within the purview of the participant. Consequently, participants took actions that were intended to

change the immediate situation for the patient, but did not directly change the status quo within the acute mental health care system.

Working through Team Relationships

Figure 2 Risking Vulnerability: Working through Team Relationships

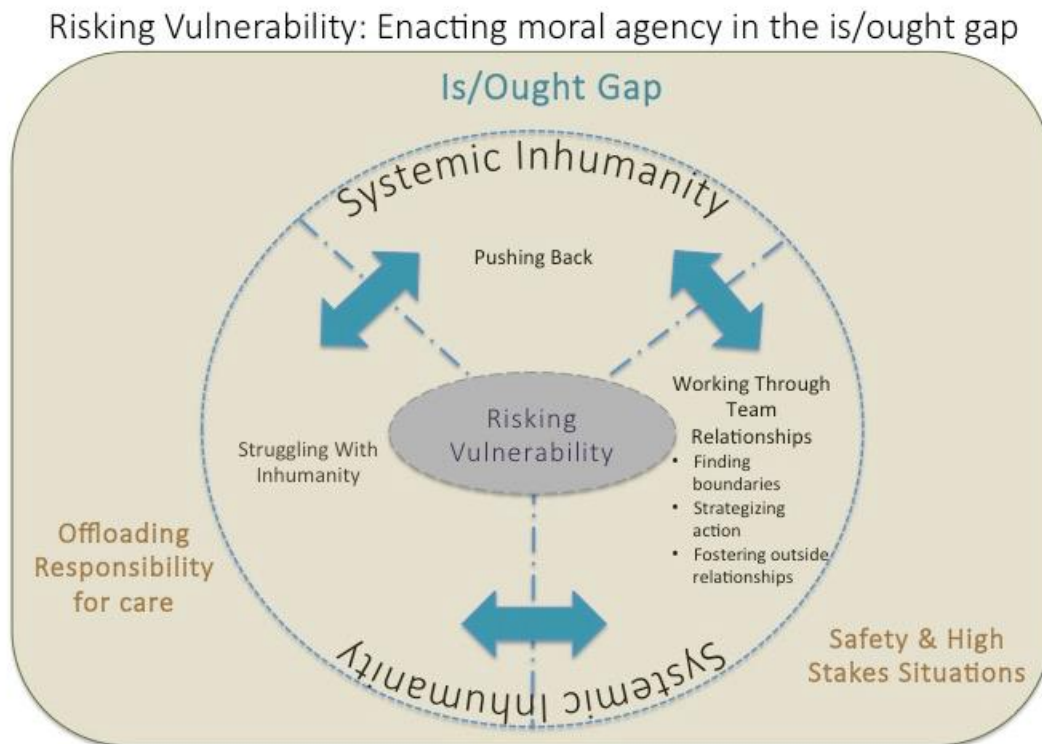


Figure 5.2 – Working Through Team Relationships

Working through team relationships is the category where participants described how they worked with, and through, their team to enact their moral obligations (as much as they saw as being possible) in an ethically challenging situation. Some participants described their team as professionally and emotionally safe, such that they could share their concerns, reflections, and questions about the situation without fearing reprisals of some sort. In this

context, the team members were willing to explore the situation, discuss options/actions the participant could take, and support the participant as she worked through the situation. This was a repetitive process that participants described as a positive experience, one that strengthened their connection to the team and its members. Positive outcomes that resulted, as participants risked vulnerability with their team, included fostering a sense of professional identity, professional credibility and reputation, and their own sense of agency within the organization. The strategies used by the team as described by participants included *finding boundaries*, *strategizing actions*, and *fostering outside relationships*. Below, I outline these subcategories, and provide examples from the participants as if the subcategories are discrete from each other. However, as noted above, the subcategories described below were iterative, and participants continued to go back to the team for discussion as they navigated ethical challenges.

Finding Boundaries. This subcategory reflects the process whereby the team helped the participant determine the extent of his or her responsibility in the situation. Through discussion, the team helped participants determine the extent of their professional responsibilities and professional obligations in a specific situation and context. The team did this by drawing on job descriptions in order to discern clearly the responsibilities expected of a person in the particular role the participant occupied. The team also highlighted what was possible within the organizational context by encouraging the participant to draw on the available organizational resources.

In *finding boundaries*, participants, through self-reflection, or discussion with the team, recognized the ethical aspects of the situation and determined that they had an obligation to take some sort of action. However, participants were frequently uncertain about where their professional obligations ended. Often, taking action required participants to confront organizational practices, such as the sharing of confidential patient information with outside agencies, that could potentially put them in conflict with organizational policies, people in positions of authority within the organization, or other HCPs. In these kinds of situations, participants were often uncertain about the extent to which they could take action, given the particular role they occupied. The team served as a resource to help the participant understand the extent of his or her responsibilities and actions in the situation.

The core category of *risking vulnerability* involved participants first taking their concern to the team for discussion, then, with team support, taking their ethical concerns to other people or programs within the organization. When participants brought these stories to the team or individual team members in *working through the team*, they wanted help to figure out what actions they could, and should, take that would help them fulfill their moral obligations in the situation. This meant that, through discussion, the team served as a place to sort out, and balance, the participant's organizational role regarding professional responsibilities and obligations. An important aspect of using the team to help discover the boundaries of responsibility was that the team members also helped identify what fell *outside* of the participant's role.

For example, Reese³² shared a story that characterized the process of how the team helped him find the boundary of responsibility, or obligation to act. As a member of a middle management team, he experienced a situation where he believed he was being used inappropriately in his role to address an employee performance issue that impacted patient safety. The situation involved performance management of an employee providing direct care to patients, and the ethical issues at stake for the participant were quality of care, and ultimately, patient safety. The participant was asked to address the concern from the perspective of his role within the agency. Although Reese worked with the employee as requested, his belief was that the central issue of underperformance related to qualities specific to the employee (lack of motivation or desire to practice up to the minimal standard), and as such, fell outside of his authority to address. The result was that he was unable to address the actual issues related to the employee's performance and the identified ethical issues. A key concern for Reese was that he was unclear about who had the authority and responsibility to address issues of patient safety that related to the practice of individual employees. Reese explained, "It's really unclear what situations require practice support, what situations require performance management, and what we three [co-leaders on the team] should be responsible for." Lack of clarity in responsibility and authority meant that the safety of patients under the care of this particular employee continued to be at risk.

³² I have used pseudonyms and randomly assigned genders to the participants to mask their identity.

To help gain clarification, Reese initially brought the situation to individual team members, and then to the whole team. The team members acknowledged that they also struggled with similar situations, experiencing uncertainty related to knowing who actually had authority to intercede in more complex cases of performance management that fell beyond the employee needing general support or oversight. *Risking vulnerability* in this situation meant that Reese, as a relatively new team member, exposed his professional credibility and developing reputation by bringing up ethical concerns about employee performance that went beyond the initial request to *teach* the employee about minimal practice expectations.

In response, Reese found the team a safe enough venue to open up a discussion about differing roles, responsibilities, and professional obligations. The team members reacted by coming together and drawing on organizational resources to help them work through the situation. This included meeting with a Human Resources advisor who walked the team through different scenarios in order to clarify the different roles on the team. The outcome of this process for the team was that Reese was able to draw up a decision support map differentiating practice support issues from performance management issues. In this way, team members were able to draw clear boundaries of responsibility around their roles. Perhaps more importantly, Reese's confidence in the team grew, and he stated:

I think it gave me confidence in the team, that if something difficult were to come up, that this is a team I could approach. This is a

team that would listen. And this would be a team that would be interested in finding a solution. And I felt resolution.

The resolution described by Reese was evident during a period of observation with this team. I witnessed a brief meeting where the middle management team came together to discuss some issues of the day across the program. One issue related to an employee whose practice in the SR opened up the patient and staff to risk for harm. Members of the team concurred that this was a pattern of behaviour specific to this particular staff member that needed to be addressed. They very rapidly identified who was responsible for tackling the problem, and came up with a plan to meet with the employee. In *risking vulnerability* to address ethical concerns, Reese initiated a process that was incorporated into how the team dealt with similar situations in the future.

Not all examples of *finding boundaries* were as obvious as the one described above. A concern expressed by several participants was the (mis)use³³ of the MHA to certify and hold patients against their will in an acute care setting

³³ I use the term (mis)use of the Mental Health Act (MHA) because I am ambivalent about how the MHA was used in these situations. I believe the MHA was used in a way that was not intended by law makers because patients were forced to remain as inpatients and live in an acute care unit for an extended period of time without an Axis 1 diagnosis (a formal mental health designation). Having said this, I have attended two inservices given by a lawyer who stated that the provincial government is aware of the ambiguity in the MHA and has chosen not to clarify the law further so as to allow psychiatrists to have flexibility and to use their clinical judgment. In situations recounted by participants where the MHA was used in this way, there was a strong belief that these patients would die on the streets if the MHA was not invoked. One participant addressed this issue directly in a conversation, stating that BC has the most flexible MHA in Canada. As well, several participants spoke of “walking the line” with the MHA and potentially “crossing the line” at times.

until appropriate housing could be arranged. In several of the accounts, patients were held for extended periods of time, up to and beyond a year, in an acute care unit, even though they either didn't have an MH diagnosis, or participants felt the patient no longer met the criteria for certification. The ethical concern voiced by participants related to discerning what was really in the best interests of the patient. For example, Riley recounted wrestling with finding the boundary around her responsibility to advocate for patient autonomy. She discussed the dual importance of being a self-reflective practitioner and of having a responsive interdisciplinary team in order to walk through the process of balancing patient autonomy with a paternalistic approach, stating:

Openness of the interdisciplinary team to suggestions and ideas and thoughts is really key, so that if I'm doing the self-reflection, it doesn't feel like for, for naught because any ideas I come up with or changes that I want to make are usually received well by the team. Like, I actually feel like my voice is heard in the team.

This quote shows how Riley engaged in *risking vulnerability* by sharing her self-reflections on her practice with her team as she struggled to find the boundary of her professional obligation to advocate for what was in the best interest of the patient. Though difficult, in Riley's discussions with team members, the team members sought to hold in tension the patient's long-term goals with the time needed to establish the resources available in the broader system.

Riley acknowledged that these discussions were common and necessary, and that they took place on a regular basis in practice, stating that the discussions were

kind of like the bread and butter of mental health. It's that helping people along that line. Like where we're trying to be as, let them be as autonomous as possible, but also hopefully offering all this other stuff that they would never be able to access on their own.

Riley spoke about how she didn't believe the team crossed a boundary when they used the MHA this way, however they did step very close to the line. One of the ways they worked to keep from crossing that boundary was through ongoing team discussion and occasionally checking with the health care agency resource from the Ethics Consultation Team:

...talking to the interdisciplinary team, saying "I'm uncomfortable with this, I've thought about it and I'm uncomfortable with it." "I think we should try to change the plan to be more inclusive [of the patient's voice]"

Finding boundaries involved ongoing discussions with the team, as well as drawing on organizational resources, such as the Ethics Consultation Team, that helped team members explore the underlying motivation for treatment decisions.

The ethical challenges described by participants often involved ongoing situations in which treatment decisions frequently had to be revisited. Below, Erin elaborates on how the venues for discussion and organizational resources helped him find, and maintain, the boundary of his professional obligation:

So we discussed at team care rounds, the physician and I discussed at length. We had case conferences with the house and community partners where [the patient] was living and these atrocities were happening, as well as with case managers and nurse practitioners in the community who were working with [the patient] and saw this stuff happen with [the patient]...[the treatment decisions] still didn't always feel that great, so then we brought in our ethics committee and had an ethical consult, with as many of the players that could come and sit at the table...So, you know we had been questioned on several levels, right? Just in conversation and whatever else, about what the process was and what our goals were. And to speak to it and feel confident and good about the decisions we were making and why we were doing them...

These discussions occurred over a one-year time frame until the situation resolved. Erin described how, over that period of time, team discussions, and the Ethics Consultation fostered confidence in his decision-making and fortified his resolve as a moral agent.

In *finding boundaries*, participants described how having regular exposure to the team through interdisciplinary meetings, along with discipline and role-specific meetings, helped create a space where their voice could be heard. Riley acknowledged that the team didn't always agree on the best course of action. However, because he had a space to voice his concerns and hear the reasoning of others, he was able to understand their perspectives. The discussions and

exposure to different perspectives helped Riley clarify and fulfill his professional obligations to patients.

Working with the team to *find boundaries* also served to buffer participants from experiencing moral distress, because, through discussion with their team, they were able to take action that transformed an ambiguous feeling of moral obligations into concrete terms. Riley described teetering at the edge of, but not falling into, moral distress:

That's how I would stop from actually experiencing the moral distress side...I think, calling the ethics board, or talking to the interdisciplinary team, saying "I'm uncomfortable with this," "I've thought about it and I'm uncomfortable with it"

At the same time, as the team helped the participant in *finding boundaries*, they also helped legitimately to limit what the participant had to take responsibility for. In the example above, for instance, the team helped Riley recognize her responsibility to advocate for the patient, but not take responsibility for the outcome of that advocacy when the decision-making authority rested with others.

These examples show how participants used formal and informal discussions with interdisciplinary team members to help them find the boundaries of their responsibilities and professional obligations. In finding the boundary of responsibility, participants were able to work to the edge of the boundary and feel confident that they had, at least partially, met their professional moral obligations. Team discussions, or discussions with individual team members, were iterative,

and interspersed with the other strategies identified in this category, *strategizing action* and *fostering outside relationships*.

Strategizing actions occurred when participants drew on the knowledge and experiences of team members to navigate institutional resources, policies, and barriers, and help them live up to their moral obligations. *Strategizing actions* occurred in formal and informal ways, as participants wrestled with ethical challenges. Participants used individual team members and team discussions to help strategize about the possible actions they might take, and the avenues available to them, as they worked through ethically challenging situations. Two threads ran through stories about *strategizing actions* with the team: these included that (a) the participant had an expectation that the team would be helpful and supportive, and (b) their expressed reliance on the professional credibility of team members who had a long history working within the organization.

Participants brought ethical issues to the team for discussion for different reasons; sometimes, participants were relatively new to the profession, organization, or role, and looked to the team for direction. At other times, participants looked to the team for strategies that they may have overlooked. When participants brought ethical challenges to discuss with the team, they *risked vulnerability* by exposing gaps in their knowledge about how to navigate the system. In *working through team relationships*, participants expected that their team would step into that gap. Kelly spoke about what was helpful as she walked through ethical issues, and stated that “I just expect that if I reach out to

some of my colleagues, that they'll be willing, and they'll listen, and provide some feedback." Participants acknowledged that team members' longevity within the organization and in the profession, along with familiarity about how the organization functioned, fostered professional credibility, and the ability to trust that the actions suggested by the team would be helpful. For example, Sasha, having worked in the organization for just over a year, described the importance of being able to speak with someone who had awareness of the organizational processes, beyond the formal reporting structures. According to her,

There are so many internal politics and...he [colleague] also recognizes the need...we would need to consult. It's risk management or something. He would sort of know.

Having confidence that the team would help fill-in the gap in knowledge about how to live up to professional obligations in their specific organization served to embolden participants as they acted on the strategies for actions suggested by their team members.

Direct care and middle management participants provided examples of *strategizing action* with their team, although the organizational structures that fostered participants' abilities to draw on the support and expertise of their colleagues differed at each level of the system. For example, at the middle management level, *strategizing action* often occurred at regularly scheduled leadership team meetings, whereas for direct care staff, *strategizing actions* was more spontaneous and occurred throughout the shift. At times, direct care, and middle management teams struggled with the same ethical challenges; however,

some of the actions or options open to the teams differed or appeared to differ.³⁴

One of the key differences between the middle management and direct care teams was that *strategizing action* often occurred at regularly scheduled team meetings. This meant that middle management participants had built-in opportunities to bring up issues, discuss the ethical aspects of a situation, explore ways to address the issue, and receive support from other team members. In contrast, direct care team members intentionally had to create space or work within the ebb and flow of the busy-ness of the shift to find time for ethical discussions. Regardless of how meetings occurred, *strategizing actions* had similar qualities in both middle management and direct care teams.

Alex provided a description of one of the ways that *strategizing action* happened formally in the leadership team during a team meeting. This process occurred when team members pooled their knowledge and experience to come up with possible options for taking action, when one of their team members asked for advice on navigating challenging ethical issues. Alex provided an example of the process, stating:

Like, okay, today “what do we have to brainstorm.” And usually someone is able to come up with...People bring up options and stuff, right, so that’s sort of a pretty standard in our group now

³⁴ In some of the situations, the options open to middle management were not open to staff at the direct care level. For example, direct care staff seldom negotiated with community organizations for services. Nonetheless, organizational resources, such as the Ethics Consultation Team, were available to all employees, however, direct care staff were either unaware of the resource or did not take advantage of it.

In this description, Alex spoke about how *strategizing actions* had become a regular part of team meetings at the middle management level. Although *strategizing actions* often happened in a formal way at leadership meetings, I observed that the process of brainstorming also occurred at informal or impromptu meetings of the leadership team as they checked in with each other throughout the day. For example, the leadership team outlined options and developed a plan around managing staffing issues across the program in an ad hoc meeting.

Mackenzie provided examples of the fluid nature of *strategizing action* with direct care team members. Mackenzie shared several stories about the difficulty of trying to balance the complex individual clinical needs of highly acute patients in an inadequate space, with the overall safety of staff and patients. Mackenzie described the process of working with the team over a period of several days, moving between strategizing, and enacting the strategies. This particular example was centered on *strategizing actions* as a dynamic process of working to provide care that aligned with the participant's professional obligations. The ethical issues at stake centered on giving care that caused the least amount of harm to the patient, who was confined in an SR for several days. Exemplified in the description was a process that held the clinical and therapeutic needs of a patient in tension with an unpredictable milieu:

because when we have somebody in the [security room], well...on our unit we work as a team. We advise each other, we assess each other's patients, we give each other feedback, we support each

other. “Okay I’ve got your back what do you want to do about it” kind of thing. So when we have someone in the [SR], there’s a constant dialogue with our colleagues about what we see, what we want to do about it, what our plan is.

Mackenzie went on to describe a team process that was fluid and flexible, because the plan to remove the patient from the SR was dependent on the current mix of patients and staff. It also depended on the team’s assessment of the patient’s ability to manage their emotional states in an environment with higher levels of stimulation. Despite the challenges of space, with the unit being at overcapacity, the team worked to respond therapeutically to the patient.

In *Strategizing Action*, the team members became a resource for the participant as they suggested options or avenues of action that were available to the participant. As with the subcategory of *finding boundaries*, *strategizing actions* contributed to the sense of having a cohesive and collaborative team.

Lee described her experience of the team this way:

Very cohesive team. We’re all the most different people you could imagine, and it works. You know, I think we’re very different leaders, we’re very different people, but we have very good collaboration. We can recognize each other’s strengths. We can recognize each other’s deficits and it’s not a finger pointing blaming situation. I think everybody’s looking at improving what they can in the program and within their own teams and everyone tries to help each other out when things aren’t going well.

The elements of collaboration and cohesion Lee described fostered a sense of moral agency in participants who had access to this team process, and they developed a level of trust that they could tease apart complex issues in a safe environment. Having said this, the ethical challenges participants spoke about were often ongoing situations, whereby participants returned to the team on a regular basis for support, in order to sustain moral action.

Fostering outside relationships is the subcategory of working through team relationships that happened when the team pointed to strategies that required the participant reach outside of the immediate team or organization for a solution, and to forge relationships with others, in order to meet their obligations. An example of this was when participants needed to foster relationships with community partners to establish resources for a patient.

Participants relayed two categories of stories about ethical challenges that required collaboration with outside agencies. The first category often involved complex mental health patients who had a dual diagnosis or a forensic history requiring more specialized community resources and follow-up. The complexity of procuring appropriate discharge services for these patients meant that they remained in the hospital for extended periods of time, up to one year in some cases. Procuring community resources involved building relationships with those who had greater decision-making authority within the organization and across health care agencies. The second category related to dealing with staff who were incompetent, unprofessional, or both, whereby the participant needed to form relationships with Human Resources, the union, or the regulatory body in order to

meet their moral obligations. In the context of these ethical challenges, the enactment of moral agency often reflected ongoing action, because participants remained engaged with the unresolved ethical situation. The result was that participants described situations in which the ethical issues at stake remained constantly in front of them when they were at work; this was particularly true for direct care staff members who seldom left the unit. The ongoing or recurring nature of the ethical challenges meant that the strategies suggested by the team involved *continuous* actions, resulting in the participant having to remain involved with the situation until it was resolved.

When participants spoke about the ongoing nature of ethical challenges, they expressed feeling frustration, ambivalence, or uncertainty about their own actions, and the need to go back to the team for reassurance. For example, Morgan spoke about the sense of being “on the fence at the beginning, about whether what we were doing was ethically sound,” as he navigated an ethically challenging situation that lasted approximately one year. He walked through the ethical issues by both going to the team for support, and also forging partnerships with community agencies that held responsibility for organizing resources. Morgan described going back and forth between his team in the mental health program and the community partners, as he sought support for his ongoing moral agency directed toward supporting the patient. At the same time, he continued to draw community partners into addressing the enduring need for a specialized placement for a patient. When participants had to forge relationships outside the immediate team, such as in the example above or when

working through complex performance issues, they used the team as a home base to which they would return, so they could be encouraged to maintain ongoing action.

The length of time it took for organizations to resolve some of the complex ethical challenges also contributed to participants' need for regular support from the team. For example, Lee talked about the frustration he experienced over the length of time it took to deal with the professional practice of an unsafe employee. He recognized the necessity of following due process, in order to achieve the best outcome for patient care, and for the HCP whose practice was called into question. Lee's description of the role of the team during this period characterized how participants engaged in *fostering outside relationships*:

I would say that a lot of conversations with both my [manager], conversations with my [peers]...and we had a lot of conversations. Sort of debriefing, venting at times when you felt very frustrated, and just trying to work through and trying to see it from, I guess, the other side of why you have to follow process. Because if it's not done correctly this will fall through the cracks. And just sort of try to wrap my head around that aspect, instead of "this is my concern, this is where I am," but "this is where they're coming from." So really, I think that just a lot of support from my other staff and colleagues.

In the above description, the participant illustrates how some participants drew on their formal team for support over a longer period of time, as they worked

through complex ethical issues. This process also included having to form partnerships with people and organizational resources outside of the immediate team, including direct care staff on the unit, Human Resources, and the union. However, it was the immediate team that provided the necessary support to help Lee manage his frustration, as the road to timely action remained a problem.

Many of the examples of *fostering outside relationships* were focused on caring for vulnerable or marginalized patients, such as those with a dual diagnosis or a forensic history. In these accounts, participants reflected a sense of obligation to care for, and protect patients, seen as vulnerable or marginalized, in society. Vulnerable patients were identified as those who, for various reasons, were at risk for harm, exploitation, or death, if some form of therapeutic intervention was not made. In many interviews, participants expressed a sense of obligation to care for those labeled as vulnerable. In their stories, they reflected on the impact of *offloading responsibility for care*, and spoke of organizing the necessary services for patients whose complex needs crossed several ministerial mandates, such as CLBC, Forensic Services, and community mental health services.

Participants noted that a common ethical challenge in these cases related to vulnerable patients being kept in an acute care setting, as an Involuntary Patient under the MHA, even though they did not appear to meet the criteria for Involuntary Status. For example, one participant talked about keeping a patient with a cognitive impairment and concurrent substance use issue hospitalized for an extended period because:

[his/her] safety was at significant risk and s/he didn't have the capacity to protect, care for, or advocate properly for [him/herself]. S/he had severe addiction and a fractured family system. And, you know, we kept them for upwards of six months and the dilemma was...we were keeping somebody in an acute care psychiatric bed. We didn't officially have an Axis1³⁵ [a formal mental health] diagnosis. (Terry)

This patient was kept in hospital until appropriate housing could be arranged, because the patient was seen as being at high risk for exploitation. In these accounts, participants attributed moral action to balancing the principle of patient autonomy with the patient's risk for exploitation, and possible death, and arranging appropriate services for these complex and challenging patients.

Participants reported the importance of receiving support from the team, and they held these ethical challenges in tension and developed relationships beyond the immediate team. Once these relationships were formed, participants fostered relationships outside of the immediate team by tapping into a wider range of resources available to meet their moral end goal. As well, participants had other people and agencies to draw on for support when they felt frustrated or

³⁵ Up until the publication of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Ed. (DSM5)* (2013), psychiatric disorders were organized across five dimensions that related to mental health conditions. Axis 1, referred to primary mental disorders, such as depression, and Axis 2 referred to personality disorders and mental retardation. Although the *DSM-5* move away from multiaxial diagnoses, participants in this study continued to refer to mental health diagnoses as "Axis 1" or "Axis 2". In order to maintain integrity with the participant's meaning, I have retained the language used by participants.

uncertain about the ethical issues. Having said this, often, gaining access to resources and supports outside of the acute care mental health system remained a challenge.

Summary. For the most part, participants had little choice in who was part of the formal team when they stepped into a new organization or position, because these teams were established by organizational structures. As such, the characteristics of the team were often entrenched prior to the participant joining the team, although the participant may have been able to influence the team. The significance of this is that the team held the capacity to both shape and limit the actions a participant was able to take. *Working through team relationships* involved a team context that supported a participant moving toward enactment of their moral agency. The characteristics of a team that participants experienced as supportive included providing a space for their voice to be heard, being respectful, and validating the concerns brought to the team as ethical concerns. When these characteristics were present, along with the opportunity to discuss ethical concerns, participants were able to *find the boundaries* of their professional moral obligations. Participants also described *strategizing actions* with the team as helpful in situations that were ethically challenging, because team members shared experiences and actions that were effective in similar situations. Sometimes the strategies suggested by the team included *fostering outside relationships* whereby the team supported the participant to foster relationships with people working outside of the immediate team to achieve their moral end goal. In some situations this meant the participant fostered

relationships with people working in other areas of the organization, such as Human Resources. In other cases it meant that participants formed relationships with people outside of the organization, such as people who worked in community mental health services.

However, participants in this study described different experiences of a team, even within the same organization. This meant that participants also encountered teams that significantly inhibited the enactment of moral agency when confronted with ethical challenges. At times, participants described an environment in which they *struggled with inhumanity*, and the team, or collective team behaviour, was itself a significant, but not the only, source of ethical challenges.

Struggling with Inhumanity

Figure 3 Risking Vulnerability: Struggling with Inhumanity

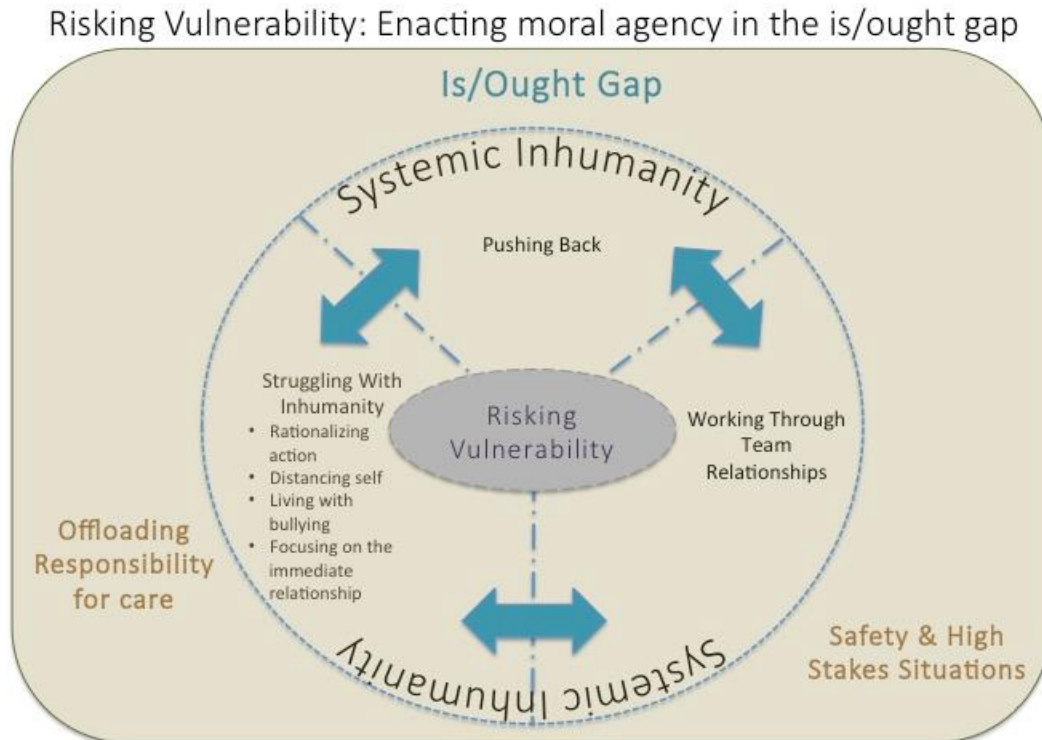


Figure 5.3 – Struggling With Inhumanity

Struggling with inhumanity is what participants experienced once they recognized the ethical nature of the situation and took some form of direct action, only to discover that their actions appeared to be ignored or dismissed by colleagues and/or those in authority. When *struggling with inhumanity*,

participants experienced moral dissonance³⁶ between the care being provided and their professional values. All participants struggled to varying degrees with *systemic inhumanity* in the *is/ought gap*, and took some form of moral action. However, participants who had their initial attempts to address inhumanity dismissed or ignored, internalized the spoken or unspoken message that they were impotent to effect any changes in the system that would mitigate or alleviate the dehumanizing treatment of others. The consequence was that participants continued to experience internal distress in that work place, with few legitimate avenues for bringing practice into alignment with professional obligations. In order to mitigate the impact of *systemic inhumanity*, participants *risked vulnerability* by taking small, individual actions, attempting to interject moments of humanity in the care they provided. Examples of behaviours witnessed, or experienced by, participants that compelled them to take action included bullying of patients and other staff, patient abuse, and providing minimal care to patients.

³⁶ Cognitive dissonance is a concept put forward by Leon Festinger and refers to the tension that occurs when a person holds two cognitions that do not psychologically fit together (Festinger & Carlsmith, 1959). Lowell (2012), in his research with managers and moral dissonance, states that cognitive dissonance is such an uncomfortable state that, “we intuitively try to reduce it, sometimes by moderating our actions, by far more often through self justification” (p.18). One aspect of dissonance that Lowell highlights is that dissonance has magnitude and the greater the level of dissonance, the stronger the drive to reduce or eliminate it. In this study, to ameliorate the distress caused by moral dissonance, participants had several choices, e.g. they could rationalize the contradiction between professional values and the care being given. Alternately, participants could employ external justification by pointing to causes that were outside of their control (Lowell, 2012). The subcategories in *Struggling with inhumanity* reflect actions participants took to decrease the moral dissonance they experienced.

At times participants could point to systemic policies, processes, or both, that set up the conditions for the inhumanity that occurred. One example of systemic policies that participants identified related to the linking of funding to decreased wait times in the ED. That is, participants talked about how patient assessments were rushed in an effort to decrease wait times in the ED. In these cases the inhumane care or abuse of others that resulted from these policies were likely unintended consequences, however they were built into the context in a way that helped obscure the lack of dignity and respect in the delivery of care to particularly vulnerable patients. Furthermore, participants articulated how policies and processes were used as excuses to provide minimal care to vulnerable patients or to keep these patients out of the health care system altogether.

It is important to note that, in *struggling with inhumanity*, participants took initial action when they became aware of an ethically challenging behaviour or situation, often by bringing up the situation with colleagues or with their direct supervisor. Yet, when their actions were either dismissed or ignored, the behaviour or situation continued. In some cases, participants identified their environments as “toxic,” “unsafe,” or having a “culture of bullying,” and participants were clearly warned or threatened that if they took further action, they would become the target of bullying or exclusion from the team. How did they live with this? When participants experienced a pattern of having their attempts to address ethical issues dismissed or ignored by colleagues and those in leadership, they expressed feeling as if they worked in an environment that

they were unable to change. Instead, participants looked for ways simply to remain in the unit or department. For example, Ariel discussed significant problems with bullying by “strong personalities”³⁷ on the unit that contributed to unsafe situations. However, when she raised the issue of bullying with her manager, her concerns were dismissed:

I’ve raised some issues with my manager...my manager didn’t say anything...[he or she] says it’s “these are interpersonal problems and we don’t need to deal with it.” But if you don’t deal with it, it’s going to just continue, right?

Participants found themselves in a position where they could choose to leave the environment altogether, or choose from a limited range of options that ultimately supported maintenance of the status quo in the environment.

A particularly salient example of a leader ignoring and rationalizing abusive behaviour came from an interview with Cory when he spoke about an incident that occurred when he was a new graduate. According to him, when Cory started a new position on a mental health unit, he witnessed an episode between a staff member and a patient in the SR very early on. He believed the incident should be reported as professional misconduct in patient care. As a new person to the team, Cory spoke to the person in charge of the shift, who had also witnessed the event, and expressed his concerns, and his belief that the behaviour needed to be reported. During the conversation, Cory “got the sense” that he was being “tested” by the person in charge to see if he would be

³⁷ “Strong personalities” was a euphemism participants used when they spoke about a bully and bullying.

someone who could be trusted on the team. Cory described the interaction this way,

I don't want to say the word "threaten," because that's too strong of a word but it was definitely insinuated that this was not something that was going to be opened up any further and I certainly got the sense that [he or she] was testing me to see if I would be going above and over the...my duty to report, to my direct supervisor....To see if...I was going to make a report above [their] position. That...would have [set] other balls rolling in terms of discipline of the staff...and I certainly got the impression that that was not the desired behaviour on my part at that time.

Although Cory hesitated to use the word *threatened*, he learned that to report the incident further would result in negative consequences in terms of his ability to become a trusted member of that team, a clear threat to his development as a professional.

Cory went on to explain that he responded to the covert message by trying to make himself known to team members as a solid practitioner, so that they would understand his work ethic and standards. Cory believed that, once known by the team, he could approach these situations directly and act more effectively as a moral agent; in the meantime, Cory found his capacity to enact moral agency constrained in this environment. The immediate supervisor's dismissal of Cory's concerns is an example of how those with positional power or influence on

the unit contributed to (consciously or unconsciously) maintaining the status quo in toxic or unsafe environments.

As a consequence of experiencing constraints to their moral agency, participants working in these environments chose actions that provided emotional and psychological protection and that allowed them to remain a part of the team. At the same time, they attempted to mitigate the harm caused to patients as a result of others' unprofessional behaviour.

Struggling with Inhumanity is comprised of four strategies participants used to enact their moral agency in ethically challenging situations: *rationalizing action*, *distancing self*, *living with bullying*, and *focusing on the immediate relationship*. I discuss each of these next.

Rationalizing action. The subcategory of *rationalizing action* occurred at both the organizational and individual levels. At the organizational level, organizations explained away the disrespectful, undignified, and inhumane response that MH patients received. At the individual level, rationalizing action is a protective strategy participants used to explain why these responses were acceptable. Organizations were able to obscure and tolerate inhumane care through policies and practices that were underpinned by the discourses of efficiency and inadequate resources. As noted, the problem participants were trying to navigate was *systemic inhumanity*, which was revealed in the way people were treated in the health care system. Some participants characterized working in environments where they experienced significant constraints on their moral agency as a source of their own moral distress, and frequently described

treatment of others that lacked respect, compassion, and dignity. Specifically, participants identified bullying³⁸ behaviour of colleagues that was demeaning or shaming of others, and diminished participants' capacity to provide humane care, as significant ethical challenges. Often, participants were able to identify how colleagues rationalized these actions as acceptable, given the circumstances and setting.

The discourses of efficiency and lack of resources were frequently used to justify inhumane treatment. For example, participants often attributed the need to be efficient, and move patients through acute care rapidly, as the underlying justification for policies and practices that dehumanized vulnerable patients. A few participants even relayed that, when they attempted to interject a level of respect and compassion for patients (i.e., to humanize care), their efforts were dismissed, or their clinical abilities were called into question as being inefficient, implying, therefore, that they were poor practitioners. The discourse of efficiency threaded through many of the stories in this study; however, participants in the

³⁸ There is a large body of literature that outlines the prevalence and problems of bullying behaviours in health care organizations. A range of terms and definitions exist that describe disruptive behaviours that impact on the emotional, psychological, and physiological health of HCPs, as well as patient safety, including incivility, harassment, lateral violence, and horizontal violence (Griffin & Clark, 2014; Houck & Colbert, 2017; Stanley, 2010; Vessey, Demarco, & DiFazio, 2011). For the purposes of this dissertation, I draw on Vessey, DeMarco, and DiFazio (2011) work on bullying, harassment, and horizontal violence (BHHV) to define bullying as the participant's descriptions fit within this definition. Vessey, DeMarco and DiFazio define BHHV as "repeated, offensive, abusive, intimidating, or behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining self-confidence" (p.136).

ED, where pressure for quick patient flow-through was the greatest, provided the clearest examples of how organizational processes built the conditions for inhumane care into the setting.

Participants provided several examples of how the discourse of efficiency was used to rationalize inhumane care. One example of an organizational process contributing to systemic inhumanity was the use of Canadian Triage and Acuity Scale (CTAS)³⁹ scoring to triage ED patients to the level of care deemed appropriate. Several participants working in the ED discussed how patient care decisions based on CTAS scores negatively impacted patients with mental health issues. CTAS scores are used for the assessment of the acuity of patients presenting in the ED, including patients presenting with mental health disorders and patients who present in the ED with a combination of physical complaints and mental health complaints. However, medical researchers acknowledge HCPs have great difficulty accurately applying CTAS scores (Clarke, Dusome & Hughes, 2007; Brown, Clarke & Spence, 2015). During interviews, participants described how CTAS scores were used inappropriately to move medically compromised patients with mental health issues into the mental health area of the ED, where there is less capacity for medical monitoring and intervention. As

³⁹ The purpose of CTAS scores is to establish a standardized metric for determining the level of acuity of a patient and identifying how quickly a patient should receive medical intervention. In an effort to decrease ED wait times, the Ministry of Health (MoH) in BC ran a pilot project that tied wait times to incentive funding (Cheng & Sutherland, 2013). Participants identified this practice as having a negative influence on the care of mental health patients. I discuss this topic further in the final chapter.

well, the funding incentives attached to ED wait times⁴⁰, measured by the CTAS scores, contributed to severe overcrowding in the mental health area, adding to the pressure to move patients through quickly without regard for the patients' actual needs.

Ellery, for example, explained how CTAS scores could be used to move patients brought in with a Fentanyl overdose out of a monitored bed and into the mental health area quickly. She gave this account:

So say if you were at [hospital name]...they have absolute policies in place that say that anybody that is suspected of having any Fentanyl use must be on a monitored bed⁴¹ for a period of time, the reason being is that Fentanyl sneaks up on you and hits you later on when you're not expecting it, right? And die. At [hospital name] they will put a person...let's say they come in by EHS [Emergency Health Services], through the ambulance, and you're in one of those EHS beds. The physician will come in right away and that person will come to us within 45 minutes, an hour, and say, "They open their eyes when I talk to them."

⁴⁰ In 2007–2008, the BC Ministry of Health initiated a "Pay-for-Performance" pilot project in an attempt to decrease wait times in the ED. Funding incentives were paid based on patients being seen within the allotted timeframe established by CTAS measures. For more information please see Cheng and Sutherland (2013).

⁴¹ A patient in a monitored bed will have their vital signs, O₂ saturation, and cardiac functioning displayed on a monitor above their bed and on a monitor in the nursing station. Thus, a monitored bed is appropriate for use with a medically unstable patient, as could be the case in a potential overdose.

According to CTAS scaling, patients who are able to open their eyes and engage with medical personnel when they are given a shoulder shake are given a CTAS that results in the patient being considered “non-urgent,” requiring reassessment every 120 minutes. As such, they can be moved to an unmonitored bed. In the case of a patient with an overdose or mental health history, this meant the patient could be moved into the mental health area, which does not have monitored beds, even though the ongoing effects of drugs such as Fentanyl might continue to compromise their physiological status. During the process of this research, I heard a few accounts about patients who died of a suspected Fentanyl overdose in the SR, apparently without monitoring. Ellery attributed the decision-making in this situation to the need for rapid patient flow-through, as well as an overall aversion to having mental health patients in the medical area of the ED.

Ellery provided this description of the need to move patients through the acute care services rapidly:

On all the units as well, there’s pressure, pressure, pressure. “Get ‘em out, get ‘em out. Do it fast, do it fast.” Right? Same with the psychiatrist. If we have 23 people in the [MH area in the ED] the first thing that management does is they go to the psychiatrist and say, “You’re going to discharge this many people. I’m not asking if they’re okay to be discharged, I’m telling you you’re going to discharge”

In a practical sense, participants discussed how the performance incentives based on CTAS scores influenced policy at the local unit because organizations

were reluctant to place a cap on how many patients could be located in the mental health area of the ED. Although participants did not offer official reasons for the reluctance to limit the number of patients being cared for in the mental health area, several linked it to the need for efficiency and an overall organizational effort to not having patients being seen as having to wait in the triage area. The consequence was that an area with a physical capacity of 14 patients regularly housed twice that number of patients with acute mental health issues.

Overcrowding of the mental health area of ED raised the sense of chaos, increasing the potential for aggression while decreasing the staff capacity to provide quality patient care. Participants described practices, ostensibly designed to speed up assessment and discharge that, in fact, contributed to disrespectful and inadequate treatment of mental health patients. These practices included conducting an inadequate assessment on patients and deflecting patients out of the ED. During one period of observation, one of the mental health staff members proudly told me that the staff group was “Excellent at keeping people out of the ED.” This staff member went on to say that she had heard from staff in other EDs that they did not appreciate this because those same patients went elsewhere seeking services. The patients who were denied services, or who were deflected out of the ED, were often those who presented with substance use issues. Some mental health staff rationalized that deflecting patients out of the ED meant the staff group was very efficient at moving patients through acute

care services, thus uncritically reinforcing the discourse of efficiency and promoting systemic inhumanity.

In both accounts above, the spoken and unspoken drive for efficient flow of patients through the health care system was literally built into policies that contributed to, and rationalized, practice decisions that too often failed to provide safe, respectful, or compassionate care to mental health patients. Another way that policy and practice were used to build inhumane care into the acute care system was through patient care plans. Several participants shared stories about how individualized care plans were used to rationalize the practice of maintaining difficult-to-manage patients in the SR for long periods of time or to rationalize the provision of minimal care to a patient in crisis.

Cary spoke about how a patient's care plan was used to rationalize the provision of minimal and time limited care in the ED. In this account, Cary described a commonly occurring situation with patients who showed up in the ED with a diagnosis of Borderline Personality Disorder (BPD), a stigmatized diagnosis. Some patients with a diagnosis of BPD had a pattern of showing up in the ED on a weekly basis, in a state of crisis, wanting admission to the hospital. In these types of cases, a care plan would be developed collaboratively between the acute care team and community team working with the patient. The care plans would allow a three-day stay in the ED to help stabilize patients by assessing their current state, assisting them through the crisis, assessing their resources in the community, and adjusting resources as needed. Cary described how, instead, she observed that colleagues used the existence of the care plan

to justify discharging these patients after three days without regard for the situation that instigated the patient's crisis:

[W]hen they have a diagnosis of BPD, and they have a care plan, and they come into ED, and you have to follow the care plan. In particular, they [the patient] have a three-day stay or something and then you have to discharge them.... I mean the psychiatrist will see them but this patient will still say, "I'm still suicidal," and then staff will even walk them off the property, "cause *they're done*. Their three-day stay is over." I find that challenging because you're thinking, "but the patient's still telling me all this ...what's changed from Day 1? They're still in distress." They're [the patient] still finding it challenging but they're [staff] like, "oh they're BPD."

The therapeutic intent of the care plan was to support the patient in developing the capacity to self-manage their emotional crisis. Cary described that, instead of following the intention of the care plan, staff focused on simply *allowing the patient to stay in the ED for three days*, minimizing the potential therapeutic purpose. The effective attitude of the staff was, "We've done our part. We gave you the three-day stay." One of the strategies used to minimize the patient's presenting concerns, if she or he had a regular pattern of showing up in the ED, was to dismiss the concerns by labeling the patient as "chronic." The label served to dismiss the expression of suicidal thoughts as illegitimate or not serious, therefore requiring only limited supportive actions. The central ethical issues for participants such as Cary were related to how the patients were treated, and to

their sense of professional responsibility for discharging a highly distressed, potentially suicidal patient. In these situations, patient care was both rationed and rationalized: it was rationed in terms of cost to acute care services, and HCPs rationalized the provision of minimal care to the patient based on a diagnosis and care plan rather than on clinical assessment.

A second discourse that pervaded the interviews and served as a rationalization for inhumane care was lack of resources. Participants provided examples of how people in senior leadership used the inadequacy of resources to justify maintaining patients in the SR for extended periods of time, sometimes months. For example, in environments that were unable to accommodate behaviours such as serious aggression, patients were often maintained in the SR for extended periods of time. The patient groups with difficult-to-manage behaviours tended to be those with a forensic history or with a dual diagnosis (intellectual delay with concurrent mental health diagnosis).

Sasha shared an account of one of these patients during an interview. The ethical challenge Sasha faced was that she and her team had to maintain a forensic client in an SR for several months before space could be found in the forensic system for this patient. The difficulty for Sasha, other team members, and the patient was that the patient had a long history in the provincial forensic hospital and was being sent back to that hospital, *when space was available in an indeterminate time frame*. This meant that Sasha, and other team members, had no certainty about how long this situation would go on. In the meantime, the patient was placed in a facility that did not have appropriate space to provide for

his or her basic human needs in a respectful way. Sasha described the patient's aggressive behaviour as purposeful and designed to move the patient back into the forensic system. As Sasha explained, "... and we know [he or she] would have had more freedom in jail." Sasha clearly identified the care being provided to this patient as dehumanizing, describing care as follows: "...like in a wet Attends [adult diapers]...[his or her] rights were being completely...[he or she] had no fresh air for months...We would try and humanize the experience as much as possible." As a consequence of having to maintain a patient in such a restrictive environment, Sasha admitted the experience tipped her into moral distress, and she expressed a deep sense of frustration, stating "There was a frustration from sort of a more organizational level, that tertiary [care] was failing this patient, or in the sense, not just the patient but failing us."

As in other participants' stories, initially Sasha took action by advocating for more humane care in an appropriate setting. Her actions were rebuffed, and the conditions of inhumane care were rationalized due to a lack of resources in tertiary settings. This meant that Sasha (and the patient) continued to struggle with inhumane care for months, until the patient could be transferred. *Risking vulnerability* in this case occurred when Sasha took smaller actions at a unit level to support staff, such as taking over care of the patient for a shift.

Participants drew on more than one strategy to lessen the cognitive dissonance and moral distress they experienced in *struggling with inhumanity*. At times, participants also used *rationalizing actions* to mitigate the effects of working in an environment that tolerated bullying. Over the course of the

research, it became evident that participants often euphemistically referred to HCPs who engaged in bullying behaviour as having “strong personalities.” Ariel recalled having discussions with colleagues when considering going to work in more acute areas of mental health. Her colleagues expressed the belief that these areas tended to attract HCPs with a strong personality. Ariel spoke about the language used in the discussion with her colleagues as they warned her about having to develop a thick skin or tough exterior if she wanted to work in these areas, stating:

I think that that is also something, especially going into high acuity areas, that the language that is used a lot before as sort of like a precursor or if you can't handle it [strong personalities] you don't belong here and these sorts of things...I've heard this in different areas and I feel like it's, you're pretty much getting warned about the abusive working environment (*laughter*), and then if you can't either adopt the same strong personality or if you can't modify your practice or your emotions or something too, so that you can work successfully in that area, then you don't belong there

This warning served unintentionally to rationalize and normalize bullying behaviour, first by accepting that this behaviour existed in high acuity areas, and second, by implying to practitioners who wanted to work in these areas that they would not be successful if they could not change their behaviour to align with the abusive culture that already existed in those environments.

While Ariel was clear that she did not agree with this sentiment, as time went on, her way of dealing with bullying behaviour was to ignore it and focus on her own practice. Ariel acknowledged that bullying behaviour was so much a part of the culture in the high acuity area in which she worked that she did not believe her colleagues even recognized the behaviour as bullying, stating:

I think that it has become so engrained and that's the language that people have heard in terms of the behaviour that they're seeing and that is bullying, but it's been labeled as strong personalities or "suck it up" or "that's how we do it here"

Ariel rationalized the culture when, a few sentences later, she spoke about the difficulty of working in a highly acute environment, and stated, "If you can't operate in those environments.... I think it's not shameful but ya... you just can't cut it." In expressing this belief, Ariel illustrated that she had incorporated, to some degree, the above comments from her colleagues into her own belief system about working in high acuity areas in mental health. It also demonstrates how an environment that tolerates bullying and disrespectful behaviour is maintained and perpetuated in the system.

Other participants confirmed this perspective on bullying behaviour by explaining that, at times, it was necessary to have a "strong personality" when working in high acuity areas such as the ED, because people in the mental health program had limited input into how patient flow would be managed. Erin relayed a story about overcrowding in the mental health ED that was, in part, related to a senior co-worker who had a

reputation for bullying staff and patients in the ED. Even though the conditions were unsafe, this co-worker overrode her colleagues and refused to stop admitting patients. Erin was deeply disturbed by the negative impact this colleague's behaviour had on staff safety and patient care. However, as Erin talked about the situation, she also began to rationalize why it was necessary to have a "strong personality" in the ED stating:

They [mental health staff] don't have any authority over anything else, so in their defense, this individual's defense, [she or he] has to deal with Emerg and [she or he] gets the pressure, and has to deal with the management, has to deal with the inpatients, deal [with] strong personalities that are telling them what to do. Because if you say no...then...it doesn't go well.

In justifying bullying behaviour, Erin apparently overlooked the distinction between taking a strong position and advocating for the needs of patients and staff in the mental health area, and becoming an impediment to working through an unsafe situation. The particular scenario Erin described, an unsafe situation in the mental health area of the ED, could not be resolved because her co-worker's strong personality impeded efforts to follow existing policies and guidelines that may have helped ease the situation.

Distancing self was one of the strategies participants used to be able to stay in the unit or program where they worked, and to try to mitigate the impact of inhumane care on patients and staff. Participants had a clear sense of

professional identity and obligations. When participants relayed incidents that lacked compassion, respect, or dignity, they would hold these incidents up against their professional identity or the values of their profession. When they described the incident, they spoke about what a good nurse or doctor or social worker *ought* to do in those circumstances. For example, Billie defined “good care” from a nursing perspective when she spoke about the ethical challenges she faced in confronting professional practice issues:

[G]ood care is [when] you are doing everything in your power to make sure that when [patients] are coming into your system and into your program, that their needs are being met.... that they're treated like an individual human being, they are important. That they feel comfortable. That they feel like they're accepted. Not being judged.

Billie's definition of “good care” reflected her assumptions about the values of the profession that ought to be present in professional relationships. Participants needed to find ways to remain grounded in their professional identity when they worked in an environment that, not only did not reflect their professional values, but also had barriers that constrained moral action to create change. Participants remained grounded in their professional identity by finding ways to *distance themselves* from behaviours that they viewed as antithetical to their discipline.

Participants discussed several different ways in which they were able to create space for themselves from organizational practices, or the behaviour of colleagues that they found reprehensible, disrespectful, or lacking in compassion,

yet were unable to change at that point in time. The strategies included: remaining in casual positions, so they had control of where and when they worked; moving between units or programs; or taking a different position within the program that had more formal authority (e.g., a position on the leadership team), in an effort to change a toxic culture.

Some participants combined the strategies of working casually with moving between units and programs. For example, several participants were direct care nurses who were trained in both psychiatric and medical nursing. These participants explained that, when working in mental health became overwhelming, they would move to medical areas of nursing for a while. Tony described the benefit of shifting to different areas of nursing like this:

I find that's been the most helpful, because if you're in the mental health area of the ED five days a week, that pressure to perform at a really fast rate and get the most amount of people out of the door, that pressure, I don't feel that same pressure in the medical area of the ED, 'cause they have medical results and all that.

It is interesting to note that Tony worked in the ED in both medical and psychiatric capacities, and identified specific factors that made working in the medical area of the ED less stressful. These factors included concrete clinical tests, such as lab work and medical imaging that informed a medical patient's condition and treatment. The medical area also had patient and staff resources to support practice decisions. Having tangible evidence that corroborated the patient's story of illness or injury, and could guide clinical interventions, appeared

to legitimize a patient's right to be "cared for," and made it easier for these participants to justify responding to patients from a position rooted in their professional identity. Some participants who worked in both areas used the experiences of providing care that aligned with their professional values as an anchor point when they returned to a difficult environment, such as mental health care.

Several participants spoke about *distancing self* by moving away from direct care work, to take a position in middle management that had more formal authority. These positions included those at a DC2/ED2, DC3⁴², and excluded management positions. These participants expressed the hope that moving into a position with more formal authority would give legitimacy to their attempt at creating change directed toward interjecting some humanity into how the acute care system responded to mental health patients. One of the participants explained that she moved away from providing direct patient care into a leadership position in an effort to try and shift the culture on the unit, from one filled with cliques that fostered negativity, to a more collaborative culture that

⁴²DC2/ED2 and DC3 are union job classifications that describe, in a generalized way, the job profile of positions at that pay scale: DC – Direct Care and ED – Educational Activities. I have chosen to use union job classifications because each site had unique titles that could potentially identify the Health Authorities or sites involved in this study. Many of the positions at a DC2/ED2 level included responsibilities of first line supervision of those who "deliver care/programs/services, and accountable for the work of others" (HEABC and Nurses' Bargaining Association, n.d., p. 8). Manager positions were excluded from the union, had responsibility for operating and the capital budget, and provided leadership for the mental health programs, along with responsibility for employee performance issues.

fostered quality patient care. She used her positional authority to start putting resources in place to facilitate collaboration between and among colleagues. However, using legitimate authority was not always enough to create change at the direct care level.

Although this participant stated she had some success in drawing in some of the direct care staff and providing support for quality practice, she also shared some of the difficulties she faced as she tried to maintain the momentum for change that she was nurturing. These difficulties included resistance from some of the “strong personalities” providing direct patient care, and imminent changes to the management structures named earlier:

I took a position hoping to create change, but now I’m hoping that regardless of [a change in management]...that we have some momentum going. But there are strong personalities who didn’t like that, because I was breaking down the clique. Now that the bigger clique is broken down to smaller cliques and it’s a matter of just bringing in more staff and bringing in more qualified staff. We’re making a learning environment, making sure there’s support up there, you know. But now, again management is changing, and the program coordinator position was taken away, so now there’s no, no support in place for me to do anything. I’m just kind of trying...

Ariel acknowledged that she would continue to use her positional authority to try and change the culture of the unit. At the same time, Ariel recognized that she

may be unable to create the shift she was working toward because the ethical issues were too great for one person, stating:

So some of the things I'm doing are, I have started to bring everybody in. Getting them to sit down, look at the process, what's working, what's not working...but do I have actual...do I have the skill set to change the whole culture? I can't do it alone, no I don't. I need the support of other people

The quote from Ariel was typical of the participants who moved into positions with more organizational authority in the hopes of creating change that reflected professional values and obligations. These participants recognized that acting as a moral agent, and confronting ethical challenges, could not be done alone; they required support from all levels of the health care system.

Living with bullying. Participants across disciplines and at different levels of the organizational hierarchy relayed stories of bullying. The bullying actions were directed at both patients and staff, and also occurred in a top-down manner between manager and staff. The majority of participants who told stories about bullying, also took some initial actions that were either dismissed by those in authority, or that resulted in retaliation. The consequence was that participants gave up attempting to intervene overtly; although some participants described taking covert actions to mitigate bullying that impacted patient care or was specifically directed at patients. Overall, this subcategory reflects participants' belief that when there was a bully present in the work environment, and management failed to act decisively or the bully was a manager, there was little

they could do to stop the behaviour. Subsequently, the bullying behaviour became pervasive to the extent that participants referred to it as being part of the culture of the unit or program. The range of bullying behaviour relayed by participants in this study included threats of physical violence, intimidation, threats to job position or promotion, and threats related to being accepted as part of the team.

Bullying from superiors. A few participants shared instances of bullying by managers directed at those under their authority. In these accounts, the bullying resulted when HCPs challenged the manager's authority in some way. Jordan described how a whole unit was bullied by a manager, and called it a "reign of terror." This bullying ensued after the staff collectively rejected a nurse that had been hired into a leadership position, who had been hand selected by the manager. The person in the leadership position was to be responsible for coordination and supervision of staff on the unit. Jordan went on to explain that the proposed leader was not familiar with the organization, or with the nursing job requirements, and the relationship between the nurses and the new leader deteriorated quickly. According to Jordan,

[The Leader] had no knowledge of what [their] job was or what our job was, or what to do, basically. It became quite a bad dynamic, quickly. So, a lot of hostility...It was a gong show, you know? There was just a lot of crazy stuff happening...not collegial, not professional stuff. But probably on both sides.

The result was that the leader's lack of experience and knowledge led to requests for staff to perform duties outside of their job description. When staff attempted to address the situation with the leader, her response was to become hostile, making it difficult for the staff to view the leader as a competent professional.

As the relationship deteriorated, some staff, individually, attempted to discuss the issues with the program leadership team and the manager. However, Jordan indicated that their concerns were dismissed, and the situation continued to deteriorate until staff members took collective action, through the Union and Human Resources, to address the leader's unprofessional behaviour. After this, the leader remained in the position, but only for a short time and then quit. Although the staff had successfully advocated for themselves in this case, it was after this that the manager began the "reign of terror" with staff members she felt had challenged her authority to appoint leaders.

Jordan described that during this period, the unit became known as a problem unit and a "pariah in terms of getting needs met, getting things fixed, just being heard in general." Although the staff had been able to take collective action to address issues with the leader, they were not able to confront the issue of bullying by their manager. Jordan described management protecting their own, stating, "[s]o I think they protect each other. There's an old boys' network happening in there." Jordan described having to live with the behaviour of the manager, as a consequence of not being able to address the bullying directly, while at the same time looking for ways to mitigate the effects of the bullying. The

bullying behaviour included threats of physical violence against some staff, as well as threats to their professional reputation. During this time, the bullying was both overt, in the form of physical threats directed at specific staff members, and covert, whereby staff felt the manager called their professional practice into question.

Jordan also spoke about staff feeling professionally unsafe when the manager called his practice decisions into question. This led to staff members worrying about their professional reputation, as the manager questioned their practice decisions and followed up by suggesting that the staff may need to be supervised as a result of having their practice questioned. Jordan explained it this way:

[The manager] could say things about your practice that you have to be able to defend, and you can't always defend your practice. Mostly you can, but you know [the manager] can make you...[the manager] can put you in a position where you feel, you know, wobbly.

During this "reign of terror," nurses began to feel uncertain about their clinical decision-making, as well as about what the manager was saying about their professional practice to others.

Further, the manager participated in gossiping about staff members. Jordan summarized this as an unsafe time on the unit, stating that:

I mean this [manager] was capable of saying anything. [The manager] didn't seem to have any boundaries on what [s/he] was

capable of doing. We certainly didn't feel safe...We didn't feel professionally safe either. We all thought that, you know, what's [the manager] going to do? I mean [the manager] could do anything. You know?

The outcome described by the participant was that nurses felt powerless to address the behaviour of the manager. Instead, the staff focused on protecting their professional reputation and supporting each other, while at the same time, providing respectful and compassionate care to the patients. The ethical issue for Jordan was the dichotomy between what was expected of them as professionals and how the manager was now treating them:

We were expected to be respectful with them, respectful with the patients, respectful with each other, but they didn't have the same, there was no requirement for them to treat us in that way. And they could just impose things on us. They could say terrible things about us. There was no reciprocity in terms of respect or...absolutely none.

In this description of how HCPs could be treated by their manager, Jordan also captured the essence of the *is/ought gap*. Jordan stated that, for approximately one year, staff members had no voice in the organization, and they were viewed as a problem unit. Although the participants were not able to identify why the bullying stopped, over the period of a year, the bullying slowly dissipated.

Bullying from peers. As noted in the introduction to this section, at times, participants framed bullying behaviours between peers in veiled terms, such as

having a “strong personality.” For example, Teegan initially started to talk about an ethically challenging situation related to overcrowding in the ED, however, as the story unfolded it became clear that it was a story about bullying that made it difficult to work through the situation that day. In this situation, Teegan, who held a position on the Leadership Team for the Mental Health Program, was called to provide support. The unit was overcrowded and had already exceeded the limits in their capacity to provide care, yet more patients were being brought into the area. As Teegan attempted to understand the situation, and make a plan based on the organizational policies and resources, she found her efforts stymied by a person with a “strong personality.” Attempting to come up with a solution meant gathering the team together to discuss options. Teegan struggled to bring people together, but his difficult colleague had taken over the situation, and continued to accept patients, although there was no room, even for patients to stand. Eventually this colleague dismissed Teegan, stating that “if you can’t do assessments then... I don’t really need you.”

This situation demonstrates disrespectful treatment of a co-worker by dismissing his/her efforts to provide support, and the staff nurse’s tendency to view middle management as just a potential extra pair of hands, rather than as consultants to help them improve practice. It also demonstrates the capacity of a bully to thwart an attempt effectively to problem-solve a difficult, and increasing dangerous, situation, and that bullying can be initiated at, and across, diverse organizational levels. Teegan described the ethical challenges in this situation as being specific to safety, in particular, how to maintain the physical safety of both

staff and patients in the mental health area. As well, Teegan tried to mitigate the emotional and psychological risks to staff members, who were questioning their ability to do an effective job in an impossible situation. Most importantly, management was aware of the bullying behaviour, because there was a history of complaints about this colleague, however, the issue had not been effectively addressed. The result was that staff accepted the culture of bullying as part of this particular work environment.

Participants admitted that one of the consequences of confronting a bully on the team was jeopardizing their own professional reputation. The fallout for participants included being marginalized by colleagues, and having their credibility as an effective practitioner called into question. Tony, reflecting his sense of professional identity, spoke about how the Mental Status Exam (MSE), and taking patient histories as part of the assessment, were core components of being a competent psychiatric nurse. However, he worked in a high acuity area where there was pressure from colleagues to take no more than 10 minutes on patients who come through the department regularly, because the patient had been there “so much.” The ethical concern centered on needing to assess patients thoroughly each time they presented in the ED, rather than relying on previous assessments, so as not to miss emergent medical or psychiatric issues. Tony stated that he gave in to the pressure to provide a brief assessment because:

You don't want to make them [the difficult colleague] upset. You don't want them to think you're lazy, you know, even, or, I feel like

sometimes it is that piece that they think you're lazy when you have all that information there.

Further on in the interview, Tony clarified that comments questioning professional competence were indirect, "but there's that fear I guess because everyone talks behind your back," rather than speaking directly to their colleague. This made it difficult for Tony to provide a rationale that supported his clinical decision-making and professional reputation. For Tony, to go against his colleagues was to risk his credibility, and by extension, his reputation as a competent practitioner. Because challenges to his professional reputation were veiled, Tony felt powerless to confront the person about the behaviour. Tony agreed that he does not take all the time he wanted to take for the patient assessment, but he attempted to mitigate the potential harm to the patient that may result from an inadequate assessment, by taking more time than his colleagues determined as being acceptable.

Bullying of patients. A few participants shared disturbing accounts where bullying or abusive behaviour was directed entirely at patients. Some participants shared a story from the recent past, while others shared a story that occurred years before. Regardless of when these incidents occurred, participants acknowledged that these incidents had an impact on them, slipping them into moral distress at times. Participant stories of bullying patients, or patient abuse, were not common in this study, but were at the far end of the continuum of *systemic inhumanity*. Participants' stories in this subcategory represent environments where there was a collective narrative that management was

aware of the unprofessional behaviour, but were unwilling, or unable, to discipline the perpetrator(s) effectively; as such the behaviour had to be simultaneously tolerated and mitigated by direct care staff. However, the staff could not address the abusive behaviour directly due to potential retaliation.

Below are two examples, from different environments, that characterize how participants struggled to find ways to enact their moral agency in a culture that rationalized inhumane behaviour. The first story came from Billie, who had witnessed this event early in her career. This particular situation occurred when Billie was a new employee in the organization:

There was a patient in a locked seclusion room, a developmentally delayed patient. Very long time in the seclusion room, it was part of the care plan...intermittently aggressive but mainly a childlike person. And [the patient] was not settling very well and...wasn't being very cooperative with the requests of the staff, and it was time to have lunch. And so we went to bring in lunch and there was...not a scuffle, [the patient] was sort of bouncing around and playing around and not following direction. Refusing to have lunch in there. And the staff yelled at the patient and put the plate of food and...like flopped it onto the patient's face...flopped the...sort of slammed...not slammed, he didn't injure [the patient] but [the nurse] put the plate of food into [the patient's] face and he yelled at [the patient]. And we, after that we exited the room.

In relaying this story, Billie acknowledged that the situation was difficult on several levels, including that he was new to the organization, stating, “I was still sort of settling in and just trying my best to sort of sit under the radar until I knew where I wanted to fit with the organization.” Billie was, however, clearly disturbed by what he had seen and approached the charge nurse, who had also witnessed the incident, expressing the belief that the colleague needed to be reported for misconduct in patient care. The response from the charge nurse was that:

[T]his particular staff, who had done this was becoming very close to retirement and this would put a very bad tarnish onto their record and that the plan wasn't to move forward with any consequence to the behaviour aside from meeting with the staff to discuss the behaviour, but no further reports.

Although Billie was not informed about any meeting that took place between his co-worker and the charge nurse, he was aware that this incident was not reported in any formal way. Furthermore, and most disturbing, the subsequent charting of the encounter, which was done by the charge nurse, did not reflect what actually happened in the encounter Billie witnessed. The distress that Billie experienced, and still carries, had several troublesome elements. First, because the incident was not accurately charted, staff assumed the patient was lying when they told others about it. Second, Billie felt like he had not protected, or cared for, this vulnerable person in the way that was required of him as a professional obligation; and third, Billie carried regret that he wasn't the person to stop that kind of unprofessional behaviour. Although Billie admits to carrying

regret and guilt related to that situation, he did not see other options open to him at that point in time beyond trusting the charge nurse to do the right thing. The story reflects the culture and barriers participants faced as they tried to be moral agents when they: (a) were new to a unit or organization, (b) were uncertain about their place on the team, and (c) witnessed unethical behaviour from someone in a leadership position.

The second example was recounted by a participant who had been nursing in the same area for several years and was fully aware of the culture and consequences of trying directly to challenge bullying behaviour. Channing became emotional as she spoke about a recent experience when a difficult colleague stepped in and took over the care of a newly admitted patient. Channing described the situation in the following way:

[I]t was basically like I had done my assessment and this patient was quite paranoid. And [the patient was] having difficulty changing in the [security room] and I was giving [the patient] time, and...it was the way the [In Charge] entered the SR and started taking off his clothes

Part of the distress Channing experienced was because it was unnecessary to rush this patient at that moment in time. Channing also expressed feeling distressed over the disrespect shown toward the patient, along with the impact the treatment might have on a patient seeking help, stating, "...because you see it, you feel uncomfortable. 'Cause you think, 'What if it was me, right?' ...or if it's their first experience with mental health? Do you really want to leave it like that?"

Channing stated that the colleague who perpetrated the action was aware that it was unnecessary and wrong, stating, "It's wrong. You know it's wrong and even the person knows it's wrong. Cause they're...you know, and then later on they're like, 'oh I should never have behaved that way'." Channing went on to explain that this particular co-worker seemed to enjoy making things happen quickly. She stated, "You know they're able to make things happen really fast on the unit, rather than giving [the patient] 10 minutes to change, they did it in one minute, but they just humiliated the person." Channing felt powerless to protect the patient because the program leadership was aware of the colleague's behaviour. Those in leadership had not only failed to deal effectively with the bullying behaviour, but over time, this colleague was promoted to a higher level position on the unit. Although direct care staff may not have been aware of all the reasons the colleague was given a promotion, the message taken up was that management would turn a blind eye to bullying and abuse of patients.

As with Billie, part of the distress Channing experienced related to not stepping in and protecting vulnerable patients. Channing acknowledged that she felt like, "I'm doing my patient wrong as well, because I should have stayed in charge, but then you know with certain people, you can't." However, unlike in the previous situation, Channing knew her place in the team and knew the consequences of intervening. If she were to take action, she risked having her ability to practice as an efficient and competent practitioner called into question. Channing says that when there is a co-worker who is a bully working on the shift, she tries to act as a buffer between her assigned patients and bullying

behaviours, bypassing the colleague who is known to bully and working directly with the physicians to have the patients' needs met.

These two examples epitomize situations and cultures in which participants felt unable to counter bullying actions directly, and struggled with the lack of humanity they witnessed on a daily basis. As noted in the introduction to this category, when participants first witnessed these incidents, they attempted to be the moral agent and took initial action, only to have these actions dismissed or ignored by leadership. The effect of having their actions dismissed was that these participants no longer took overt action to confront bullying behaviour; instead, participants described taking covert actions to act as a buffer between bullying staff and patients. Participants also took action, *focusing on the immediate relationship*, to mitigate the experience of bullying. Practitioners who had to work around difficult co-workers, were able to continue working in a toxic work culture only as long as they found ways to be ethical practitioners with some colleagues and with their patients.

Focusing on the immediate relationship. Participants described *focusing on the immediate relationship* as intentionally blocking out the aspects of the practice environment they could not control and focusing mainly on the things they could control. When they did this, participants were able to provide care that aligned with their professional identity. Participants took action in an attempt to interject moments of humanity into the health care system, and this included drawing on their professional identity to guide actions, focusing on the

immediate relationship, and fostering collaborative relationships with HCPs who have some decisional power, to achieve a better outcome for the patient.

Unlike *working through teams*, in this category, when participants struggled with ethical challenges that involved inhumane care, they often described struggling alone, with no one to go to, especially if they worked on a team with a bullying colleague. Participants used the strategies identified above when they believed there were no actions available to them that would effect change in the context, so they made an intentional decision to focus on aspects of practice they could control. A common thread throughout the interviews was that, despite the constraints on moral agency, participants noted that they could make choices about the kind of relationship they wanted to have with colleagues and patients. This meant that participants' forged collegial relationships with other HCPs who would help them meet their end goal of providing care that aligned with their professional identity and values.

In therapeutic relationships with patients, participants relied on their clinical skills and knowledge of organizational policy to meet the needs of the patient. They spoke about taking actions with the intention of conveying to their patient that they were important. One participant ascribed actions that interjected moments of humanity into the relationship as fostering hope stating that, "the humane, human, daily things that make us feel like we have some hopefulness, and you know, that we're human beings essentially at the end of the day, I like to do all that stuff, right?"

Participants described these humanizing actions as “small actions” designed to convey respect and dignity to the patient, to mitigate dehumanizing treatment. Alex told this story as she talked about trying to institute small actions to humanize care:

So, we're faced with having to store people essentially in an overpopulated ED, in less than human conditions. In an urban center, in the 21st century. Some people actually scream for antipsychotics so that they can be put out, so they don't have to experience being in there. And that happens regularly. So, we try to do our best but it's never optimal. And, we asked for plastic trays, or some kind of crump-able, you know, something that's not going to injure us, to put food on, because all they have is a mattress on the floor in those rooms...to put food on, to put the food then on the bed for them, any little tray as a sort of humanizing thing. Right now we put it on the floor and the food goes on the floor like as if they're in prison. Or on their bed if it can sit there without tipping over. And we got a few trays and some of the [other staff] absolutely tore them up and put nasty notes on them and they weren't going to accept that...but we, but we're faced with an acute population that needs really sensitive monitoring and are dangerous. One guy hung himself. Another guy overdosed while he was in a [security room] because somebody didn't observe him while he was being changed and he'd hidden a syringe. And other people have knives

and drugs and, you know, it, it's quite dangerous. So it's almost a forensic setting but you still have to be human with forensic patients.

In this quote, Alex describes in her own words, the context and conditions of the everyday work environment experienced by many of the participants in this study. However, despite having to balance a myriad of competing needs, participants continued to look for ways to interject humanity into the care they provided. Although participants didn't phrase it this way, they attributed the provision of excellent clinical care as a means of humanizing patient care.

Another strategy participants used to focus on the immediate relationship was to attend to the areas of practice that they actually had control over. This meant that, at times, the participant worked independently of the team, focusing only on the needs of the person they were currently interacting with. Casey described how, when the unit was overcapacity and in chaos, she ceased to focus on the nonstop flow of patients, and instead focused on her own practice and the patient in front of her.

If I have 12 of those, or six of those lined up, it's [balancing everyone's needs in an overcrowded department] really hard to do. So I just pull back and let the chips fall where they may, because I know I can't take them all on, so I just narrow my focus and do one patient at a time completely, and move on to the next, and the next.

As this part of the conversation continued, Casey acknowledged that there were only a few areas in her job that she had control over, and in those areas, she

ruled with an “iron fist.” She did not have control over patient flow, inadequate space, or lack of human and material resources, so instead, she deliberately turned her attention to the areas that she could control, such as her own practice, to ensure that she provided quality care.

When participants chose to narrow their focus to what they directly had control over, they supported their clinical decisions with organizational policy. Several participants gave examples of using their clinical knowledge in combination with organizational policy to interject some humanity into the process of care. In the example from Ellery below, she used her clinical findings and organizational policy to bolster her argument for further medical monitoring before moving a patient to a psychiatric bed. Participants used the combination of clinical skills, and their knowledge of organizational policy, to meet the needs of the patient when they worked in difficult environments, and when they believed they had to justify their clinical decisions to colleagues who valued efficient flow-through of patients through a clinical area.

When participants experienced a sense of isolation in their area of practice, they worked around their team by intentionally cultivating relationships with colleagues across programs, disciplines, and at higher levels of authority in order to advocate for the immediate needs of the patient in their care. This was particularly true when a participant worked with bullies, and believed they would not be able to achieve the best outcome for the patient in their care by working with their immediate team. In these situations, participants deliberately worked to develop relationships with people who had decisional authority outside of the

team. A common example that participants described was cultivating relationships with physicians in order to meet the care needs of their patient adequately. One example from the ED centered on maintaining appropriate medical monitoring for patients who came in with a potential overdose (OD) of street drugs. Ellery acknowledged that medical staff considered these patients mental health clients, and as such, wanted them transferred out of medical care as quickly as possible. To work around this practice, Ellery would bypass the team by going directly to the physician to advocate for the patient, explaining:

I've built a relationship with most of the ER physicians, not all of them, but most of them, and so they're willing to listen to me when I say, 'You know what this is, what I'm seeing and I'm a little concerned about this and can we have a monitored bed for a little bit longer just to make sure that we're, we're clear, right?' Most of them will go along with me.

In cultivating relationships with HCPs outside of the team, participants were able to work around some of the environmental or organizational barriers to the provision of care that aligned with their sense of professional identity.

Although physicians were often viewed as having decisional authority in the health care system, one participant, a physician, lamented about how the systemic barriers directed at creating efficient processes limited their ability to access resources for patients. In this particular case, patient referrals were sent to a central hub for processing. This meant that direct communication between physicians across programs no longer occurred. While this process was intended

to speed up patient access to resources, it actually slowed down the process because the physician could no longer just call up a colleague and review the appropriateness of the patient for that service. The physician noted several ethical concerns that she attributed to programs being siloed as a result of efficiency efforts. In these situations, the physician acknowledged focusing on the areas of practice that she had control over. However, she also admitted that she experienced moral distress “all the time,” as she attempted to balance her ethical responsibilities to the patient and to the community.

Summary

The category, *struggling with inhumanity*, refers to the cognitive dissonance and moral distress participants experienced when they worked in environments where colleagues and patients were treated with an overall lack of dignity, respect, and compassion. Participants stated that they were unable to create change in the patient care environment at that moment in time, so instead, they took actions to mitigate the emotional, psychological, and physiological effects of inhumane care. These actions included *rationalizing actions*, *distancing self*, *living with bullying*, and *focusing on the immediate relationship*. Although these strategies served to maintain the status quo, ultimately, their purpose appeared to be to minimize harm to patients as well as to protect participants and help them in tolerating work in a difficult environment.

Participants explained that they stayed in these environments as long as they believed they could make a difference for patients, and that they could

convey a sense that the patient mattered. However, participants also had an ethical “line-in-the-sand,” and if the environment, or actions in the environment, became intolerable, the participant could take one of two courses of action. The participant could either leave the unit, program, organization, and/or profession, or the participant could *risk vulnerability*, by *pushing back* against inhumane care.

Pushing Back

Figure 4 Risking Vulnerability: Pushing Back

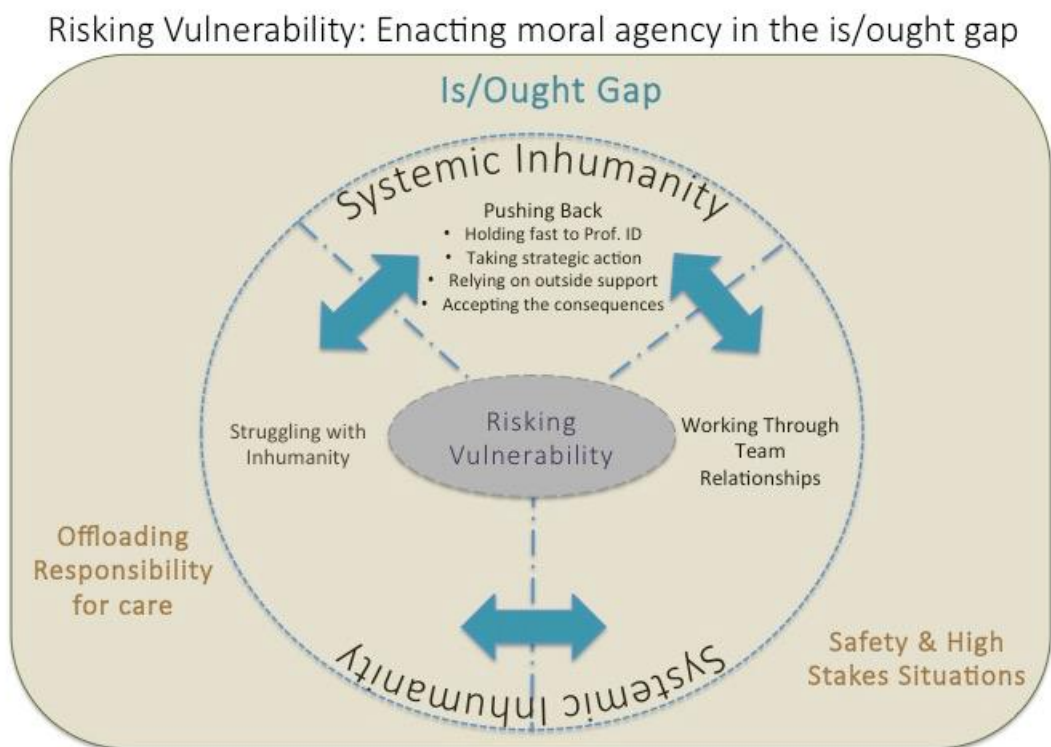


Figure 5.4 – Pushing Back

Pushing back is the category that refers to times when participants took “big actions” in response to ethical challenges. The primary goals of moral

agency in this category were to hold individuals, or the organization, accountable to professional or organizational values, and affect some (even if at a small) level of organizational or systemic change. When participants were able to accomplish both these goals, they were working toward closing the *is/ought gap* at a broader organizational level. In the categories of *working through team relationships* and *struggling with inhumanity*, participants directed their efforts toward interjecting humanity into care at an individual level, either directly with the patient or with the patient's situation. In the category of *pushing back* participants directed their action to the level of policy. This category is comprised of *acting from a professional identity*, *taking strategic action*, *relying on outside support*, and *accepting the consequences*. In this category, *risking vulnerability* meant that participants engaged in sustaining, and risking, their professional credibility with themselves, their colleagues, or within the organization. In *pushing back*, participants used the knowledge they had about the organization, including organizational policy and decision-making, as well as where they would find support, and took strategic action to effect change in specific situations.

This category is based on anecdotes from participants who took strategic action when they were confronted by a situation that crossed their ethical "line-in-the-sand": violating values the participant viewed as core to their *professional identity*. It was not clear a-priori exactly when, or under what circumstances, crossing that ethical boundary would occur, because all participants described facing significant ethical challenges in their daily practice. However, threads that ran through the situations associated with *pushing back* included the perceived

level of vulnerability of the patient(s) involved and the possibility of working around or through the situation for the patients' benefit. If participants viewed the patient as relatively more vulnerable than other patients, and felt that they were somehow contributing to the ethical boundary violation, either by directly participating in the violation or indirectly by not acting in some way, participants felt compelled to take *strategic action* to address the situation.

When participants *pushed back*, most of the situations were not isolated incidents; rather, they reflected a pattern the participant witnessed, either in the program or acute care system. Accordingly, the participant began *taking strategic action* to address the issue using professional, clinical, and organizational knowledge, drawing on *support from mentors*, and taking the issue up the organizational hierarchy. After taking action, participants were *accepting of the consequences*. Participants recognized that to take a "big action" was fraught with risks to their professional reputation and position within the organization. However, participants perceived that the ethical violation was so great that they *considered the consequences* for their actions, and were prepared to act regardless. Consequences for taking action and failing to achieve their moral end goal of making the *is/ought gap* smaller included losing credibility with the team, losing credibility with the leadership in the organization, losing their job or being demoted, and the possibility of leaving the organization or profession altogether.

Holding fast to professional identity refers to the attributes of being a professional that participants spoke eloquently and passionately about as they described the ethical situations that required them to take big risks. The attributes

participants spoke about became the impetus to taking action, along with the means by which they took action. The attributes included having their professional values guide practice. Participants also described drawing on a clinical knowledge base that was shared with other disciplines and using it from a disciplinary perspective to provide patient-centered care. Finally, participants intentionally set about fostering collaborative organizational relationships that they selectively drew on when they needed to take a strategic action as a moral agent.

Throughout the study, participants spoke about the elements that contributed to being a competent professional. Some of the elements that formed the participants' foundation for practice and their professional identity included the values they viewed as being core to the profession that guided their clinical decisions and behaviour as professionals. In addition, participants sought shared clinical knowledge from across disciplines and applied this knowledge from a disciplinary perspective. For example, some participants attended multidisciplinary workshops on harm reduction, or on the impact of illicit substances, such as crystal meth. They fostered collegial organizational relationships across disciplines to cultivate professional credibility, in order to navigate the immediate context and create change, despite environmental constraints. Examples of using collegial relationships to navigate ethical challenges were present in all three categories and included nurses forming collaborative relationships with physicians to address patient care needs. These

foundational elements of professional practice served as both a means, and an end, when participants took *strategic action* in the *is/ought gap*.

Professional values guiding practice. Through the stories they told, participants identified values they viewed as being core to their professional identity that guided their practice decisions. All participants shared several stories about ethical challenges that came up regularly in their practice. Woven through these stories were professional values that not only guided the actions of participants, but that also formed the foundation for their professional practice. Some examples of values participants identified as core to their professional identity were discipline-specific and included, for example, advocacy, empowering patients, and social justice. Nurses spoke about alleviating suffering, providing care, and offering hope; and physicians spoke about dual responsibilities of protecting the right of the patient to make a choice about treatment and protecting the public. Participants sought to exemplify the core values of their profession in their day-to-day practice, making comments such as, “I’m supposed to be an advocate for safety,” and “Social justice is one of those things that I’m passionate about, and I think it’s also one of those personal and professional values.” At times, some participants felt compelled to take action at a broader systems level when a situation threatened their ability to uphold these core values in their daily practice.

When participants who were *holding fast to their professional identity* took big actions in response to ethical challenges, their actions were directed at pushing back against the status quo of acute care mental health services. In

these situations, they looked beyond their job description to help them determine the boundary of their professional obligations. Instead, these participants drew on their core professional values and Codes of Ethics⁴³ to define the boundaries of the profession. In doing so, they had a more abstract interpretation of their respective *Codes of Ethics* that applied beyond guiding ethical decision-making in a specific situation, and toward what it meant to be a professional. Aaron captured this when he spoke about the role of the professional *Code of Ethics* in his practice:

Well, drawing on the ethics is respecting human dignity, respecting people's autonomy, um...Ya, I'm talking about the professional ethics, like being open and transparent in the work that you do, respecting your professional colleagues, being fair in the way that you provide services. You know, you don't pick and choose the patients; you work with who you've got, providing safe and competent care to the patients. You know, being accountable for the work that you do.

⁴³ All the HCPs involved in this study belonged to a professional body and had an established Code of Ethics. A professional Code of Ethics can serve several functions including the identification of the fundamental values of the profession, provide guidance for HCPs in navigating ethical situations, increase awareness of ethical issues and the obligations HCPs have to the public, and they may also be used as a benchmark against which practitioners can measure their practice (Storch, 2013). The professional Codes of Ethics that guided participants in this study included the Code of Ethics for Registered Nurses, the CMA Code of Ethics, the BC College of Social Workers Code of Ethics, and College of Occupational Therapists Code of Ethics.

As is seen in this quote, Aaron applies his *Code of Ethics* broadly, as a foundation for a *way of being* a professional. Another participant shared an example where her team did not want to provide care to someone with a history of violence, and what staff viewed as questionable mental health concerns. Leslie's position with her team was that "You can't refuse someone's healthcare access, whether you think they merit or not;" instead, she emphasized the core value that HCPs were to provide effective health care, which began with an assessment of the patient's health needs. Other participants echoed this sentiment, and Leslie attributed this stance to what it meant to be a professional. Although not all participants explicitly identified their *Code of Ethics* as the foundation for their practice, they echoed the view that the core values of the profession helped to define the boundaries of their practice as they wrestled with difficult issues related to accessing health care services and patient safety. In the category of *pushing back*, participants embodied their professional values and elevated these values beyond responding to an individual patient situation and toward responding to ethical situations as a professional with moral obligations to society.

Using shared clinical knowledge. Participants who were *holding fast to their professional identity* also conveyed the idea that a competent professional incorporated shared clinical knowledge into their practice and adapted the knowledge to their clinical perspective. An example of using knowledge from a disciplinary perspective came in contrasting treatment interventions between a

nurse and a social worker. A nurse, who spoke about using a harm reduction⁴⁴ approach when working with patients who struggled with substance use stated,

and I tell people “I’m not the cops, I don’t care what you’re using. I just need to know so that I can give you the best treatment possible and keep you safe.” ...and I might coach them on, if they’re IV drug users we talk about how they use them, where they use them, where they get supplies and how to be safe and some of the warnings that are out there...Like that’s the kind of thing as a nurse...

The nurse drew on harm reduction theory to support clinical decision-making, ultimately using harm reduction strategies to fulfill what she viewed as her professional identity as a nurse.

Another participant, a social worker, used knowledge about trauma informed practice⁴⁵ and substance use to plan discharge resources and

⁴⁴ Harm reduction is a broad approach to policy developments, practice, and programming designed to reduce the negative health, social, and economic consequences associated with drug use. Harm reduction approaches include a range of activities directed at reducing harm from drug use including, but not limited to, prevention activities, education, needle exchange programs, treatment options, and substitution therapies such as methadone (Buxton, 2009). Harm reduction is part of the overall approach taken by British Columbia to address substance use issues. For further information on harm reduction, please visit <http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction>

interventions that would foster life skills focused on harm reduction for a patient with a dual diagnosis. In both these situations, knowledge about treatment of substance use, harm reduction, and trauma informed care was available to HCPs across disciplines, however, individual practitioners applied the knowledge based on their disciplinary responsibilities and perspectives to how to best meet those responsibilities. In the quote above, the nurse used her disciplinary knowledge to teach patients about how to decrease the health risks that can accompany IV drug use, instead of focusing on the illegal aspects of drug use. In the second example, the social worker advocated from a disciplinary perspective for a treatment plan that would foster the development of life skills for the patient. Both the nurse and the social worker drew on a similar knowledge base to plan care. In this way, competent professionals used a shared knowledge base as a common foundation for working in a complementary and collaborative fashion to meet the patient's needs.

Fostering collaborative organizational relationships. Part of being a competent professional also meant knowing how to facilitate change in the organization through collaborative relationships. This was a skill, learned through

⁴⁵ Trauma informed practice is a holistic approach to providing services to people who struggle with mental health or substance use. The approach recognizes the prevalence of exposure to traumatic situations across the population and specifically within the mental health population. A trauma informed approach refers to the provisions of services in ways that recognize the patient's need for physical and emotional safety, as well as the need for choice and control in treatment decisions. For more information about trauma informed practice, please see the *Trauma Informed Practice Guide* (BC Provincial Mental Health and Substance Use Planning Council, 2013).

time and experience, that incorporated knowing how change occurred in the environment—such as the organizational process of change—and who had formal and informal power to effect change. The ability to foster change in an organization required familiarity with the organization that was possible only when the participant had been working in the organization for several years. Working in the same organization for several years also helped the participant establish a reputation as a competent professional, build credibility, and foster collaborative relationships with colleagues. Channing, for example, talked about learning how to navigate the limitations of the acute care system and the importance of collaborative relationships when advocating for change, stating:

And you can, you know, there's ways to continue to sort of advocate for change, but do it in a way that doesn't alienate you from the system...I'm always trying to be aware of the relationship. I need to, I'm going to need this person, or I'm going to use this person in the future...if I damage [the relationship] now, it's going to make my life harder the next time.

Part of being a competent professional, and being able to create change, included knowing that there were times when “you have to be able to accept that there are limitations, whatever those may be at that time” (Channing).

Participants spoke about intentionally taking care to foster a sense of collaboration across disciplines, teams, and programs, as a means of creating change. In this category, participants spoke confidently about collaborating across disciplines and teams, and either seeking those on the team with the best

knowledge in a particular situation, or sharing their knowledge with the team. For example, one of the physicians in this study discussed the importance of team-based decision-making and going to the people who had the most knowledge, particularly in ethically fraught situations. Another participant described collaborating across organizational teams in ethical situations, stating:

...we had [an] ethical consult for starters. We engaged with the community mental health team, which is also a part of [Organization name]. So, we would collaborate frequently with them, with [government agency], with basically the family, all of the community stakeholders. And we did bounce ideas around the table.

Participants who were *holding fast to their professional identity* intentionally fostered collaborative partnerships as a means of advocating for organizational change from within the acute care system.

Although participants did not identify that they deliberately fostered these aspects of their professional reputation, being a competent professional, having credibility, and fostering collaborative team relationships threaded through stories of taking action to create change. One example that captures all of these elements came from a participant working in a busy, and frequently chaotic, ED. The context of the discussion was about how, sometimes, as part of a team, professional boundaries needed to be somewhat flexible for the team to function effectively and efficiently:

...then other things, depends on my relationship with the physicians. So, when I go to them and give them the good history, over time they come to trust me. And if they ask me a question I would not lie. And if I've done it, I've done it, and if I haven't, I haven't. So they're reasonably confident that I'm doing more than my job...So, I'll go with that, if it helps the patient and the department, but never to the point where I do things on my own. And I wave at them [the physician] if they're in the trauma room, and they know, you know, acknowledge that they have an idea of what I'm dealing with, because it's usually a variation on a theme, and for me to go ahead.

This description captures the elements of competency, credibility, and trustworthiness that participants who were *holding fast to their professional identity* purposefully fostered, and subsequently drew on, as they navigated limitations to ethical care in the acute care system.

Despite having competency and credibility, participants also shared situations in which they were not able to navigate the limitations and barriers in the system without risking alienation from their colleagues, team, or organization. Participants felt compelled to act when patients, who were perceived as more vulnerable than others, and therefore, required a greater level of protection, were involved. In such cases, the vulnerability of the patient appeared to have accentuated inhumanity in the *is/ought gap*, and because of other circumstances in the environment, such as working under someone who had legitimate authority

but didn't follow organizational policy or values, participants found it impossible to work around the situation. This left them with the sense that they were contributing to the suffering of vulnerable patients, and consequently violating closely held values of their profession. Patients who were identified as vulnerable, and therefore requiring a greater level of protection or advocacy, included mentally ill patients, adolescents with mental health concerns, patients who were developmentally delayed, and those with addictions.

The category of *pushing back* is based on several stories, such as one that told of a manager who jeopardized the safe care of an adolescent by overriding policy, because she had positional authority in the organization. In another situation, patients with mental health concerns were described as being mechanically restrained in an ED, while they were waiting to be seen by a doctor. In yet another circumstance, there was a longstanding awareness, among management and staff of an organization, that specific staff members were habitually bullying others and abusing patients, and yet it was not being effectively dealt with. Participants expressed that when these incidents occurred, taking no action felt like they themselves were a part of what they perceived as unethical conduct. When faced with the sense of being complicit in causing harm to vulnerable patients, participants *risked vulnerability* by *taking strategic action* to hold a person, or the organization, accountable to espoused values, such as patient-centered care, and caring for vulnerable populations.

Taking strategic action. When participants decided to *push back*, they wanted to do more than navigate the immediate context. They actually wanted to

disrupt the status quo of the acute care mental health system and close the is/ought *gap* at least a little. This necessitated the development of a plan that involved those in the organization with formal authority by the participant. The plan was directed at influencing broader systemic change, not just the immediate situation. *Taking strategic action* involved using collaborative relationships to carry the ethical issue up the organizational hierarchy.

Participants drew on their knowledge of organizational processes as they took action. This included knowledge about the quality of the people in positions of authority. In the description below, Alex captured the essence of the strategies and processes involved when participants felt compelled to take strategic action. In this part of the interview, Alex explained the importance of using the organizational hierarchy strategically, as a means of making certain that their ethical concerns were addressed:

...[and] who's in the role and who's watching the person in the role, because if you really want to make a point, then you will send an email or write a letter. Make it patient related, which it always is, but make sure that it's patient care related, and then cc it to several different layers, levels of authority. So that more than one person knows that it's out there and someone should be responding... Then you get a response, not always a proper one, but you get one.

This statement came in the middle of a description of how to hold people with organizational authority accountable to stated organizational values. Alex went on to acknowledge that she only used this process once or twice in her career,

for those moments when “big action” was required. If she took this approach more often, she would lose credibility and effectiveness for creating change in the organization, and she would be dismissed as a complainer. Alex’s description also reflected how she was determined to make those with positional authority aware of the ethical issue, and at the same time, she risked alienation within the organization from those in positions of authority.

An example of taking strategic action through using the organizational hierarchy occurred when the Medical Director for a unit decided to have beds designated for psychiatric patients “repurposed” for medical patients. Taylor stated that the Medical Director “hated psychiatry and they wanted it out of the department.” This meant there was “no place to put psychiatric patients while we’re waiting. So, they were all tied up, and stretchers in the back literally.” Patients were perceived as vulnerable in these circumstances, simply because they were designated as having mental health issues. Tying patients up while they waited to be seen by a physician denied the patient dignity and respect, and contributed to their suffering and jeopardized their safety. Taylor acknowledged that, “[w]henever I feel that I am participating in something that’s causing the suffering or perpetuating the suffering, that’s very distressful.” Being complicit in the patient’s suffering heightened her own experience of moral distress, compelling her to challenge this practice. Taylor took *strategic action* and went up the organizational hierarchy all the way to the Director of Nursing, in an effort to hold the organization accountable to their stated values.

Taking action up the organizational hierarchy was fraught with risk for participants. They risked their credibility as a competent and ethical practitioner with both their colleagues and with the organizational leadership. If participants failed to take action, they risked losing credibility with their peers. If they took action and failed, the participant risked being viewed as an ineffective practitioner. Participants also risked their job or advancement in the agency if they took action. Yet in taking strategic action, they were aware of the risks and claimed that they were prepared to accept the consequences of acting.

Another participant regularly spoke out against organizational policies that, in her view, caused harm to patients in her care. Some of the policies also seemed to contradict an institutional narrative about caring for vulnerable patients. One of the examples related to a newly introduced protocol around methadone. The new protocol required that methadone be given in divided doses, “[s]o that at no point, until very much later in the day, does that person have their regular dose of methadone” (Reese). At the same time, physicians did not want these patients having PRN⁴⁶ medication to help manage withdrawal symptoms. The result was that patients suffered through withdrawal because they were admitted to a hospital. Part of Reese’s frustration with the new protocol was that it was not based on constrained resources or patient needs, but on “an increasing caution around medications” (Reese). Furthermore, when the protocol was developed, there did not appear to be input from those who were impacted

⁴⁶ PRN is an abbreviation for Latin “pro re nata,” meaning “as necessary.” In this context, PRN means to give medication as the patient requires.

by the policy, namely, patients on methadone, and staff who carried out the new protocol. Patients were perceived by the participants as being more vulnerable in this situation, and it was felt that simply because they were admitted to the hospital, they could not stay on their established methadone routine. Reese believed that both the direct care staff and patients suffered as a result of the protocol, stating, “But I, myself and my patients and my colleagues suffer for it...we get the outcomes of that.”

However, the deeper frustration came from the constraints placed on her professional identity. As a nurse, Reese believed part of her professional identity was to relieve suffering, yet in this situation, she felt responsible for being unable to provide relief from suffering, describing the situation this way: “I also, because they [those responsible for the policy] don’t get that I’m also responsible for this.... You know, I’m responsible for this. But I can’t have my patients suffer, right?” Reese took *strategic action* by going to the leadership of the program, and highlighting the contradiction between the stated values of the organization to provide patient-centered care, and the actual pain patients endured because of the protocol. This was only one of several examples of how Reese regularly advocated for policy that aligned with professional ethics and organizational values, and thus reinforced her professional identity. Reese *risked vulnerability* through ongoing advocacy and attempting to hold the organization accountable to their espoused values. This participant paid a high professional cost of *risking vulnerability* by speaking up and *pushing back* when policies didn’t align with organizational values. When she applied for a clinical leadership position

commensurate with her education and experience, she was told she would not move up in the organization because she did not carry the "right message" to the direct care staff.

Billie gave one further example of *taking strategic action* through both the organizational hierarchy, and drawing on resources from outside the organization. Billie spoke about a situation involving a longstanding employee who regularly breached professional ethical standards. A situation occurred when this employee refused to provide care for a developmentally delayed patient. The patient was perceived as being especially vulnerable because of having a dual diagnosis and being unable to advocate for himself. Billie, who was in a supervisory capacity, was responding to concerns brought forward from the community about the incident. Billie gave this account of the situation, and the response of the employee:

...but no planning, nothing was done and forwarded to, say addiction services, or mental health. So, in my eyes that was not good care. It was just terrible care. And then the piece that got even worse when confronted was justifying. The nurse was actually justifying the reasons why he did what he did.

In this situation, Billie felt compelled to act beyond the immediate level because "my manager at that time didn't seem to really want to pursue anything." In an effort to hold the nurse accountable for violations of the core values of nursing, for example, caring for patients, and relieving suffering, Billie decided to report the employee to the regulatory body. She stated that she did this, "with the intent

that, not to get them into trouble, but more so just to, you know, this is not the way we do nursing. This is not what we were trained to do.”

In this situation, Senior Management and Program Leadership were aware of a pattern of patient abuse and staff bullying by this reported employee, but had failed to deal effectively with the behaviour. Billie shared her decision to report the employee with her manager and senior management, who were supportive of the decision. Ultimately, Billie and the organizational management engaged in a parallel reporting process in which management addressed the employee through organizational processes, with Human Resources and the Union, while Billie addressed the issue through the regulatory body.

Relying on outside support. In this category, participants often told stories about ongoing situations that required *pushing back* over time. Several participants spoke about *relying on outside support* as they proceeded with *taking strategic action*. Support for taking actions that reflected their professional values came from members of the profession or colleagues who demonstrated competent and ethical practice. In most cases, the participants found support from outside of the immediate team. Participants talked about seeking support from colleagues whom they respected, and who had an understanding of the context in which the participant worked. Other participants talked about how their spiritual beliefs served as a foundation and support for taking ongoing action and accepting the consequences of that action.

Lee provided several examples of people he went to for support when confronted with ethically challenging situations. A primary source of support for

Lee, (who was a DC3), was other colleagues who worked at the same health authority, though at different sites. Lee described going to other DC3s when he had a dilemma because they understood the context in which he worked and had worked through similar situations. Lee shared that the group met several times in the year to discuss issues and share creative solutions across the health authority:

We wanted to do things, and creative things that, you know we're all speaking the same language. We talk about our struggles, some of those struggles were major themes, and what we want to do is do our job better...And work toward client centered care. But at the same time, we were dealing with staffing issues. We were dealing with all kinds of things, client complaints, and family complaints. There's a lot that could have been worked out and, and drawn from [each other's experiences] because I can guarantee I can go pick up the phone and call any one of the DC3s today and they'll tell you, "I'm burned out."

As can be seen from this quote, the purpose of meeting was twofold: to share ideas across programs and to support each other as they did their job. When Lee needed ideas and support for *taking strategic action*, he went to members of this group for suggestions and support.

Interestingly, this group of DC3s had originally met together regularly as a strategy for improving patient care across the health authority. After those in senior management found out about these meetings, they began to set the

agenda for discussion. The focus of the meetings was then no longer the issues that confronted DC3s; instead, the meetings became a conduit for information from senior leadership. Ultimately, senior leadership disbanded the group:

It was just starting to get strong and then, but the manager said that, “ya...I think we’re just wasting their time.” Where stuff we wanted to talk about was not really allowed to be talked about.

Lee’s perspective was that there was no trust between senior management and middle management, and the DC3s were told to go to their manager for guidance or support. Lee acknowledged they received verbal support from the manager when they attempted to deal with bullying or patient abuse, however, they received no actual support in terms of strategies, time, or resources as they worked through these issues. When senior management disbanded this group, they effectively severed a genuine source of support for taking ethical actions.

Erin spoke about *relying on outside support* through a colleague at a different agency. Erin, who worked at another job part-time, used this colleague as a sounding board to make sure her thinking and subsequent action aligned with her professional obligations:

...so, I consulted with my other boss asking, “what would I do in a situation? You’re a boss. If this was happening between you and I?” and s/he said, “[Your manager’s] asking you to violate your ethics. You can’t do that.”

Erin recounted that the situation unfolded over approximately 18 months. As Erin took strategic action, her manager attempted to make her work life more difficult,

in an effort to get Erin to quit. Part of this plan involved changing her work schedule. Over that period of time, Erin's colleague, from outside the organization, supported her emotionally and practically for taking an ethical stance. Erin described the response of her colleague: "So I will support you taking a stand with your ethics, and if [your manager] changes your schedule, I'll change mine to accommodate because I want to keep you. I don't want to lose you." As seen in these examples, some participants used colleagues from outside their immediate team to support their moral agency. At the same time, some participants also drew strength for moral action from their spiritual beliefs, which I turn to next.

One participant admitted that her spiritual perspectives helped her both tolerate the chaotic circumstances of her job, while also draw the boundary around what was unacceptable practice requiring *taking strategic action*. Robin identified a range of spiritual beliefs that informed her thinking and action. She identified drawing on some Eastern religious practices as means of helping to limit her experience of distress, stating:

And then the [idea] of limiting duality is why I can make things grey. Because when things get too black and white it can cause you way more distress and be detrimental in the long run.

"Making things grey" allowed Robin to tolerate situations where the quality of care was less than desirable, but the best she was able to provide in the moment.

When it came to making ethical decisions, Robin drew on an eclectic range of religious beliefs including Catholicism, paganism, and Buddhism when the line of humane care had been crossed. She described drawing on all of these religious beliefs, that incorporate compassion and kindness, for her ethical decision-making in the moment, stating, “[I]n the end when I come to that, that fork in the road I have to say if this was my brother or my mother, what would the decision be?” Having said this, the ethical line-in-the-sand for Robin was her involvement in *causing* suffering. Her professional identity as a nurse to alleviate suffering, her roots in paganism, and “first does no harm,” led to the full enactment of moral agency.

Accepting the consequences. In *pushing back* against systemic humanity, participants prioritized holding a person or the organization accountable to the values that framed the is/ought gap over their fear of the consequences that confronted them for taking strategic action. Participants *risking vulnerability* experienced various levels of success and support for action, and decided to take action regardless of the level of support, or the perceived possibilities of successful action, and were prepared to accept the consequences for taking action.

Jessie explained that she would have moved forward with actions directed at dealing with the bullying and abusive behaviour of one of her employees, even though previous attempts to deal with it had not been successful. Previous efforts

had not resulted in changing the behaviour of the employee. The participant described her reasons for moving forward with reporting to the regulatory body:

Oh, I would have done it regardless. I think it needed to be done, because when I look at the bigger picture, I felt that we'd gone down the same path for a period of time, and now we have a bigger incident, so clearly I thought that the person hasn't learned, and we've done the union. We've done the HR. There were discussions. It wasn't working, right? It, it did not work. So, I'm thinking, okay, what else? What have I got to lose or, I just thought, we need to try something different.

Jessie had witnessed, and been involved in, trying all other avenues open to the organization in attempts to hold the employee accountable to their professional Standards of Practice. *Risking vulnerability* in this situation meant that, by taking action, and possibly failing, she opened himself up to being seen as an ineffective leader to the staff she was responsible for. In the end, Jessie was unable to hold the employee accountable for their actions, and believed she had lost the respect of the employees, stating, "I mean they were respectful to me just to a certain degree but I felt that as soon as I turned my back they were just like, 'get out of here'." Jessie subsequently left the program. While aware of the risk she faced when she took action, the response of the staff "solidifies the decision I made to leave that place much easier."

When Leigh took action and confronted a manager whom he viewed as misusing organizational authority, he faced the risk of losing his job. The situation

occurred when Leigh was in a supervisory position. The program manager, new to the position, directed a subordinate staff member to override policy related to the safe care of adolescents on a mental health unit. Leigh met with the manager to discuss the breach in protocol, providing an explanation based on best practice guidelines and professional responsibility. While Leigh clearly viewed maintaining the safety of patients in his responsibility as part of his professional obligation, the manager dismissed the clinical and ethical aspects of professional responsibility, and instead viewed the situation from the perspective of organizational authority. Leigh stated that from that moment on, he felt caught between his professional obligation to keep patients safe, and positional authority within the organizational hierarchy.

Putting a vulnerable patient at risk by overriding clear clinical guidelines was a professional boundary violation that prompted Leigh to speak directly to the manager. However, the ethical issue arose from the fallout of taking action, which was a tense relationship between Leigh and the manager. He described it this way:

So when the manager says those [Code of Ethics] don't count, that creates a moral dilemma for me, because it's like, okay I'm supposed to be listening to your [the manager's] authority, but when you're [the manager] telling me to work unethically, and I can't do that, so I will stand up to your authority at my expense, I mean it would be at my, my professional, my career expense I guess.

The situation was resolved when the manager left the position, but not before Leigh got demoted back to a direct care position after the manager deleted his position in the program. Leigh expressed that he experienced some distress because “I did all the right things...but I still could not achieve what I needed to achieve,” which was to hold the manager accountable to ethical practice. He also acknowledged that he could not compromise his professional ethics.

When Taylor took action and went up the organizational hierarchy to the Director of Nursing because psychiatric patients were being “tied up” in the ED, his purpose was to hold the Medical Director and the organization accountable to the stated values of the organization. The organizational values included delivering care to vulnerable populations, however, the treatment that was being provided in the department highlighted the is/ought gap between the care the organization said it valued and the treatment it actually gave. As a direct care staff member responsible for psychiatric patients, Taylor was also complicit in the standard of treatment being provided. Below, Taylor describes the conversation he had with the Director of Nursing:

So, I personally went to the Director of Nursing and I said, “do you know..., if my job’s on the line, fine, but this is what I see happening. That [the Medical Director] has to be put in their place if you really believe that psychiatry should still stay in the department. If you don’t agree with them then go from there. But I believe you are not aware of the gravity of the situation and so I’m here to tell

you. If you already know it, that's okay. Let me know and I'll be on my way and I won't bug you anymore”

The Director of Nursing listened to Taylor, and within a few days, a shift in practice began to occur that aligned more closely with organizational values. By taking action, Taylor was able to close the is/ought gap to an extent. Taylor recognized that, in *taking strategic action*, he was risking his position; however, taking no action was also not an option for him as a moral agent.

In the category of *pushing back*, participants risked vulnerability in order to hold people or organizations accountable to stated values, in the hope of closing the is/ought gap at a broader systems level. They accomplished this by acting from their professional identity and allowing their professional values to guide their actions. In doing this, participants also drew on their competence, and the collaborative relationships they had built within the health care system.

Participants did not act impulsively, because they wanted to take actions that would actually create some sort of change in the way people or the program responded to vulnerable patients struggling with mental illness. Instead, participants looked for ways of *taking strategic action* that would result in lasting change. Regularly, participants spoke about relying on support that came from outside the team or the organization, as they engaged in ongoing action.

Participants were aware that the possibility of succeeding in achieving their moral end goal was uncertain. Overall, *risking vulnerability* meant that, when participants took action, they engaged in sustaining, and risking their professional credibility with themselves, their colleagues, and within the organization. To take

no action was to risk their identification as an ethical practitioner with themselves and their colleagues. However, it also meant that the participant would sustain their job. To take action meant the possibility of risking their job, yet sustaining professional credibility as an ethical practitioner.

Summary of the Findings

As noted at the beginning of this chapter, the research question I set out to answer was: how do HCPs in mental health navigate morally charged situations and enact their moral agency within their health care organizations? During analysis of the interview data, it became clear that all participants enacted moral agency to varying degrees, with differing degrees of success. In this chapter I have explained the findings about *how* participants enacted moral agency and the resulting model, *Risking vulnerability: Enacting Moral Agency in the Is/Ought Gap*. The background context that frames the delivery of acute care mental health services, and where the ethical challenges described by participants occurred, is the space between the quality of care health care organization said they provided and the quality of care that was actually provided. HCPs who participated in this study, discussed this space against the backdrop of trying to reconcile their professional values and obligations with the limitations of the health care system. The limitations identified were in the form of inadequate services available for patients and an inability, or unwillingness, of organizational leadership to hold people accountable to explicitly stated professional and organizational values.

This gap led to the basic social problem that participants had to navigate: *systemic inhumanity*, or the inability of the health care system to respond consistently and with compassion, respect, and dignity, to patients struggling with mental health issues. Participants navigated systemic inhumanity by *risking vulnerability*, or exposing themselves emotionally and professionally to the risk of losing their job/position, having their professional reputation called into question, and faced the possibility of losing credibility in the organization and with their peers, resulting in exclusion from the team.

The model, *risking vulnerability*, is made up of three categories, *working through team relationships*, *struggling with inhumanity*, and *pushing back*. In the category *working through team relationships*, participants described drawing on the knowledge and experience of their colleagues as they navigated ethical challenges. Participants described their team as supportive, and professionally and emotionally safe, to the extent that they were willing to *risk vulnerability* by exposing their own professional uncertainty in the face of ethically challenging situations. The category, *struggling with inhumanity*, refers to the experience of participants when they worked in environments where colleagues and patients were treated with an overall lack of dignity, respect, and compassion. Participants described working in isolation and not having team or leadership support to take moral action when confronted with ethically challenging situations. In fact, in this category, the team, or the leadership of the program, were regularly the sources of deeply disturbing ethical violations. The repercussions of *risking vulnerability* included bullying, exclusion, and damage to

the participants' professional reputation. In the categories of *working through team relationships* and *struggling with inhumanity*, participant actions were directed at resolving or mitigating the impact of the immediate situation or ethical challenge. Participants' actions were directed at the micro-level of the situation and the intent was not to create systemic change in the way the system responded to mental health patients. The result was that the participant navigated the immediate situation, but ultimately maintained the status quo of the system.

The category of *pushing back* describes "big actions" participants took that were directed toward holding people accountable to professional or organizational values. In holding people accountable to a values-based response to patients, participants' actions were intended to create change at a higher level of the organization in order to close the is/ought gap to an extent. *Risking vulnerability* in this category meant that participants risked their professional credibility, reputation, and in some cases their job, in order to change the status quo. Participants thought through the potential outcomes of their actions and were prepared to accept the consequences of their action in the hopes of affecting some change in the system.

Chapter 6 Discussion

Figure 5 Risking Vulnerability

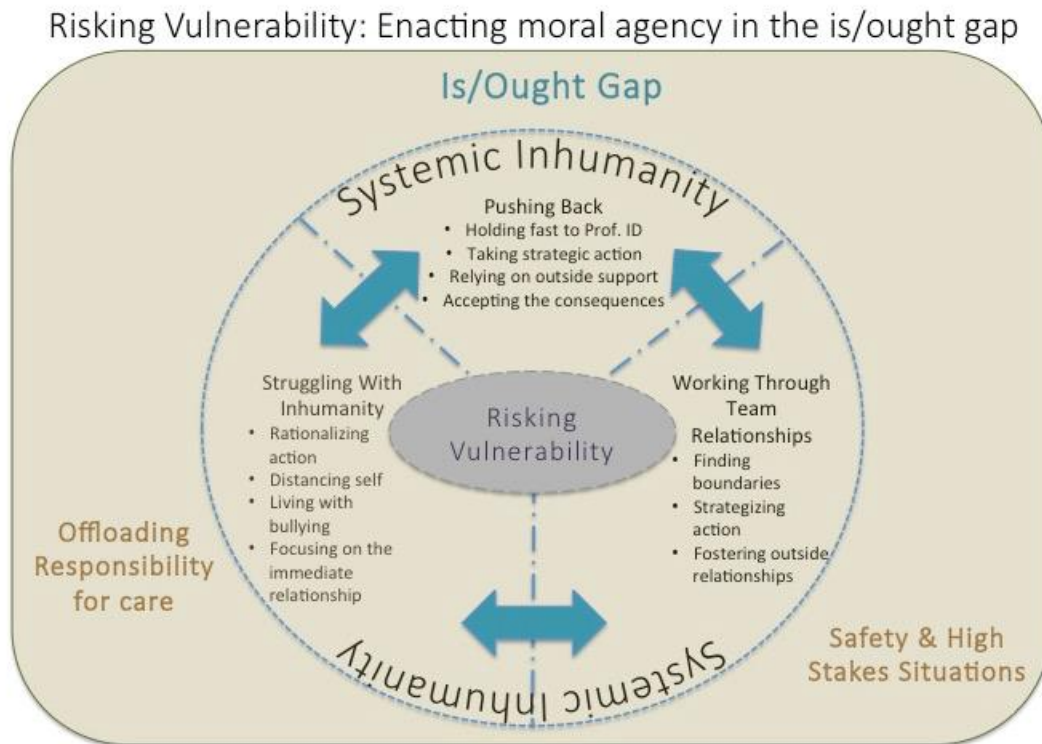


Figure 5.1 – Model of Categories of Action

I examined the processes by which HCPs working in mental health care enact their moral agency in ethically challenging practice situations. From the beginning, my intention was to bring conceptual clarity to the definition of moral distress by focusing on the role of action and examining how the current health care context shapes HCPs' ability to enact their moral agency. My analysis of findings revealed that the basic social problem participants had to navigate as they enacted moral agency was *systemic inhumanity*, or the inability of the health care system to respond consistently, and with dignity, compassion, and respect,

to patients struggling with mental health issues. *Offloading responsibility for care* is the actions taken by people working within the health care system to place responsibility for either interceding in situations of bullying, or providing care to patients, onto other HCPs, units, or programs.

Offloading responsibility for care also refers to how the acute care mental health system is increasingly taking up responsibility for patients with a concurrent mental health diagnosis and a forensic history, or a dual diagnosis (DD). An increase in admissions of patients with a forensic history and DD patients has contributed to *safety and high-stakes situations*, whereby patients and staff experience increased risk for significant harm and aggression. These key findings were the backdrop for the ethical challenges identified by participants—challenges that instigated intentional acts of moral agency. This study contributes to our knowledge of the MH systems, moral distress, and enactment of moral agency.

In this chapter, I discuss the findings of the study in the context of the extant literature that I reviewed in Chapter Two and that I have supplemented here. I also elaborate on how these findings add conceptual clarity to the role of *action* in moral distress, specifically with regard to enacting moral agency in the complex sociopolitical and interpersonal mental health care environment. I begin with a summary of the study and then situate the discussion around the key findings of the research. This is followed by a discussion of the implications for theory development, further research, clinical practice, health care professional and nursing education, and policy. Finally, I address the limitations of this study.

Summary of the Study

The purpose of this study was to develop a substantive theory of how HCPs enacted moral agency in ethically challenging situations. The philosophical assumptions that underpinned this study were rooted in a constructionist perspective, encompassing an understanding that actions taken by participants need to be understood within the context in which they take these actions. As well, I have maintained the assumption that agents and structures are open systems that have the ability to influence each other. I used GT methods commensurate with a constructionist perspective for data collection and analysis. I collected data primarily through participant interviews, observations, and organizational documents, such as vision and values statements. Data collection and analysis occurred concurrently, and continued through to the completion of Chapter Five: the findings chapter. I used constant comparison, memo writing, diagramming, and discussion with committee members to help move analysis to higher levels of abstraction, resulting in the theory, *Risking Vulnerability: Enacting Moral Agency in the Is/Ought Gap*.

Risking vulnerability refers to the actions participants took to practice in alignment with their professional Code of Ethics and Standards of Practice. In response to ethical challenges, decisions about the degree of moral agency a participant could enact hinged upon contextual elements, such as the availability of team or management support, unit culture, and broader system influences. Participants understood their own vulnerability against the background of possible exclusion from the treatment team, loss of professional credibility, loss

of advancement in the organization, or loss of their job. Participants held knowledge of their vulnerability in tension with their professional obligations to patients as they navigated ethical challenges. When participants experienced their environment as hostile or dangerous (for example, due to bullying), they enacted moral agency by balancing their own protection with providing care that aligned with their professional obligations.

The basic problem that participants were navigating in this study was *systemic inhumanity*. In their accounts, participants reflected on ethical challenges that were embedded in the policies and practices of the health care system, or resulted from the acute mental health care system taking up responsibility for patients either from the forensic population or with an intellectual disability. In such cases, participants described these complex patients being kept in conditions they described as inhumane, and/or the situation resulted in the (mis)use of the MHA. (Mis)use of the MHA refers to the process of using the MHA to certify a patient and confine him or her in a psychiatric unit until suitable housing could be arranged; in some cases, a patient was confined in the hospital for up to one year. Participants often described ethical situations that violated their professional values related to ensuring safety for patients and staff, and providing compassionate, and respectful, care that preserved patient dignity.

All participants acted as moral agents to a greater or lesser degree, directing their efforts to where they believed they could achieve the greatest change. Participants enacted moral agency relationally, meaning that they acted

at different levels of the health care system, given their position in the organization, using their political knowledge of how to effect change within the organization, and fostering relationships with people who have institutional authority. Participants also enacted moral agency through interpersonal relationships. Contextual features—for example, unit culture—placed varying degrees of constraint on their actions. Participant decisions about moral agency also included an awareness of the consequences for taking action. When participants worked in toxic environments where team members were the source of ethical challenges, they *struggled with inhumanity*, describing their options for actions as limited. They directed their actions toward self-protection while trying to mitigate the impact of unethical behaviour or practice on the patient. When participants *worked through team relationships*, they had a greater range of options for action, and focused on accessing system resources to resolve the immediate ethical challenge. Some participants *pushed back* and made decisions about what action to take, regardless of the constraints they faced or the possible consequences of their actions, based on what they believed they *ought* to do as a professional to remedy the ethical challenge.

Contributions to Knowledge

Structural Influences on Moral Agency

The *Ten-Year Mental Health Plan* (2010) was an attempt to balance the issues that shape the delivery of mental health care, meeting the needs of the

population and a decrease in available funding (Read, 2009). Key strategies to achieve Ministry goals included further implementation of a de-professionalized skill-mix and the introduction of other health care providers to team-based care (Ministry of Health, 2014b, 2014c). Yet, research on moral distress in mental health has identified structural systems issues that both contribute to moral distress and constrain HCPs' ability to act, including low staffing levels and working with colleagues who are unskilled or semiskilled (Austin et al., 2003; Corley et al., 2005). Other issues related to inadequate staffing include lack of time to form a relationship with the patient, team conflict, and hierarchical power structures (Austin et al., 2003; Austin et al., 2005; Deady & McCarthy, 2010; Musto & Schreiber, 2012).

The structural challenges of cost containment and shortages of skilled professionals are examples of structures shaping practice environments in the delivery of mental health care. There is some research in mental health nursing that has explored the connections between structural issues in the acute care work environment and burnout (Hanrahan et al., 2010). Similar to other studies examining the relationship between work environment and burnout, these researchers identified skilled leadership, appropriate staffing levels, and respectful nurse-physician relationships that acted as a buffer against burnout (Hanrahan et al., 2010). Importantly, these authors suggest that, "the strength of the relationship between organizational factors and psychiatric nurse burnout should be noticed by hospital administrators" (Hanrahan et al., p. 203).

Participants in my study often recognized structural influences at the unit or program level, and sought ways to work around structural influences. In the category of *struggling with inhumanity*, participants enacted agency by engaging in *distancing* or *focusing on the immediate relationship*. In *working through team relationships*, participants were able to address some of the structural influences, such as discuss ethical concerns about the MHA with the team. These findings support other emerging research demonstrating that structural influences at different levels of the health care system influence moral agency. These findings also highlight the complexity of the structural elements that influence practice, regardless of whether structural influences were recognized by participants.

Exploring Complexity

I intentionally chose the conceptual framing for this study as a means of examining the experience of moral distress within the layered context of the acute mental health care system. The intended outcome of exploring moral distress in complex contexts was to clarify how aspects of the health care environment interacted with personal attributes of the individual to influence the experience of moral distress. By exploring complexity, researchers have the opportunity to develop and implement interventions in ways not previously considered. As often happens in research using GT, although this study started with a focus on moral distress, the focus shifted to understanding how participants enacted moral agency in complex environments.

Implications for the Definition of Moral Distress

My research contributes to the body of literature on moral distress by adding evidence and depth to what is known about enacting moral agency in complex health care organizations. My findings enrich our knowledge by moving away from a binary understanding of moral agency—that is, participants acted, or didn't act—and toward a nuanced understanding of moral agency that explicitly attends to internal and external contexts in which decisions about action are made (Musto, Rodney & Vanderheide, 2014; Musto & Rodney, 2016 (Musto & Rodney, 2018)). Taking this view of agency, we can also see that HCPs often take action in subtle ways that may not be recognized as action. For example, participants made small acts of kindness toward their patients—such as giving them a warm blanket—to foster moments of genuine engagement in the relationship and to convey respect for persons. Acts that *humanize* the other are part of the moral commitments that nurses and other HCPs have made to their patients (Austin, 2011).

A nuanced understanding of the complexity of moral distress opens up the idea that decisions about agency are dynamic (Milliken, 2018) and made at the intersection of structure and agency. Decisions are situated in a moment in time, and are clearly embedded in both the external context in which HCPs work and in the meaning HCPs attribute to that action. In the context of moral distress, this means that the role of action might be understood as the range of behaviours the participant could take in that context. The resulting intensity of moral distress is based on the meaning the participant makes of the action.

Constraints, moral agency, and context. A debate in the literature on moral distress is related to the location of constraints on moral agency. In this study, the degree of constraint a participant experienced in an organization depended on the culture of the unit or program in which they worked, along with the amount, and type of support they received from program leadership and colleagues. Thus, for example, a participant working in the same organization for an extended period of time described the degree of constraint on her moral agency as dynamic and dependent on their current leadership and team. In some cases, where participants described extensive constraints on moral agency, they managed the distress that resulted from not being able to provide care that aligned with their professional obligations by moving to different units or programs in the same organization, where they experienced greater support. Finally, there were a few participants who described significant environmental constraints on moral agency, yet they acted, in spite of the potential consequences, such as losing their job. This further supports my original premise, that the role of constraints on action is more complex than it was represented in the original definition of moral distress.

Understanding the relationship between constraints and moral agency. Since I began this study, there has been a growing focus by scholars and researchers on trying to clarify the concepts that underpin the definition of

MD.⁴⁷ For example, Morley, Ives, Brabury-Jones and Irvine (2017) completed a narrative synthesis of the literature on moral distress to explore the *necessary and sufficient* conditions required to define MD. To accomplish this task, the authors drew on articles that explored MD empirically and examined MD conceptually, or theoretically. After a comparison of the selected articles, and a synthesis of their findings, Morley et al. examined the salient concepts, moral judgments, the psychological and physical effects of MD, moral dilemmas and uncertainty, constraints as causes of MD, and threats to moral integrity.

In their examination of *constraints* on agency as the cause of MD, Morley et al. noted that Jameton (1984) built the concept of organizational constraints on agency as a necessary condition of the original definition. The subsequent development of a quantitative measure of MD was based on Jameton's definition (Corley, Elswick, Gorman & Clor, 2001). The result was that the presupposition of organizational constraints was built into the quantitative measures of MD. As such, these instruments only measured MD that resulted from constraints on moral agency. The possibility exists that constraints on moral agency are always present to some degree, and therefore, are a necessary but not a sufficient

⁴⁷ There have been debates in the literature about broadening the definition to include other moral concepts, such as moral conflict and moral uncertainty (see Campbell, Ulrich, & Grady, 2016; Fourie, 2015; Mack, 2015). Other authors have tried to delineate the concepts of moral distress by developing a taxonomy or map (See Dudzinski, 2016; Thomas & McCullough, 2014). Yet other authors have also examined moral distress using different lenses that provide a richer understanding of the concepts (see, for example Lütznén & Ewalds-Kvist, 2013; Morley, Ives, Bradbury-Jones & Irvine, 2017; Peter & Liaschenko, 2013).

condition to the experience of MD. Morley et al. (2017) suggest that the necessary and sufficient conditions of MD are as follows:

psychological distress is a necessary condition of MD but not a sufficient one. A person may experience psychological distress linked to life events but to be properly labeled MD, it seems necessary that the distress is directly causally related to a 'moral event.' This would make the combination of (1) the experience of a moral event, (2) the experience of 'psychological distress' and (3) a direct causal relation between (1) and (2) necessary and sufficient conditions for MD. (p.15)

This definition allows constraints on moral agency as a causal link between the moral event and psychological distress; however, constraints on moral action do not have to be the causal link. Other potential causes of MD suggested by researchers include moral dilemmas, moral uncertainty, bad moral luck, lack of knowledge, and moral conflict (Campbell, Ulrich & Grady, 2016; Fourie, 2015), to name a few.

Fourie (2015) has also explored the role of moral constraints as the *cause* of moral distress. Fourie argued that constraints on moral agency may be *relevant* to the experience of moral distress, but are not necessarily central to the experience. Fourie put forward two suggestions for this argument. The first was that constraints on moral agency might be particularly germane for nurses working in hierarchical organizations that provide few opportunities for nurses to participate in patient care decision-making. This suggestion reflects the critique

that gaining conceptual clarity on the definition of moral distress has been stymied because the definition itself is grounded in the disciplinary experience of nursing (Crane, Bayl-Smith, & Cartmill, 2013; Musto & Rodney, 2018). Fourie's suggestion is to "acknowledge that moral constraint is a particular problem for nurses but without conceding that it should be built into a definition of distress" (p. 96). Fourie suggests that if *constraint* on moral agency is built into the definition as a necessary condition of MD, the definition will exclude other *morally relevant* (original italics) causes of MD, such as moral conflict about what is the right course of action. In *Risking vulnerability*, moral conflict about the right course of action leading to the experience of MD surfaced in several situations. Some of these participants did not endorse constraints on their actions; instead, these participants either worked through, or were in the process of working through, the situation with the interdisciplinary team.

Constraints on moral agency as an assault on HCPs' professional identity. The second argument is related to situations that are less about constraints on moral action and more about conflicting moral principles. My research was an interdisciplinary study that included physicians, nurses, social workers, and occupational therapists. Many participants who endorsed experiencing moral distress also described constraints on their ability to take action due to imbalances in power relationships, organizational policies and practices, or limitations in resources. However, one participant clearly described experiencing moral distress due to a situation that involved conflicting moral principles. In this situation, the interdisciplinary team took action and navigated

the situation, ultimately reaching a decision that was liveable for all parties. This advances the consideration, as suggested by Fourie (2015) and Morley, Ives, Brabury-Jones and Irvine (2017) that, while constraints on moral agency may significantly contribute to moral distress, they may not be a *necessary* condition of the experience. My findings, and other research (Musto & Schreiber, 2012; Pauly, Varcoe, Storch & Newton, 2009; Webster & Baylis, 2000) indicate that MD occurs even when HCPs take action, supporting the suggestion that constraints and moral agency have a more complex relationship than previously considered.

Participants in this study described experiencing moral distress when they felt their professional identity was being assailed, and took actions directed at (re)aligning their professional identity with their professional obligations. Recent literature clarifying the growing list of definitions of moral distress confirms this finding. For example, using a feminist lens to re-examine moral distress, Peter and Liaschenko (2013) suggested the idea that moral distress arises as a result of constraints on our “identities, relationships, and responsibilities” (p. 338), which are core elements of moral agency. The authors argue that individual moral identities are developed narratively. Although these narratives are shaped by social and historical contexts, they are also formed as individuals reflect on, and make meaning of, their moral actions. Individual reflection and meaning-making hold the potential for a person to choose to respond differently when confronted with subsequent ethical challenges. It also highlights the reciprocal nature of moral agency as a learning process, in that, people learn about moral agency, in part, by being a moral agent and then reflecting on what happened.

This learning process was evident in my study. Some participants spoke about the importance of reflecting on learning from previous experiences as a moral agent as they navigated ethical challenges.

Systemic Inhumanity

The basic social problem participants had to work around as a moral agent was systemic inhumanity. The question about what it means to be human, and subsequently how humans ought to be treated, has occupied the thinking of philosophers across time (Blackburn, 2016; Johnson & Cureton, 2017). As noted in Chapter Five, the word *humane* captures the qualities we attribute to *being human*. However, in my review of the literature post-analysis, I observed that the qualities of being human were generally not discussed directly; rather, the qualities of being human were translated into moral imperatives about how humans *ought* to be treated. An example of this is in Kant's moral philosophy; the categorical imperative served as the foundation for the idea that we may not treat humans as a means only, but also "as an end in itself. This is often seen as introducing the idea of 'respect' for persons, for whatever it is that is essential to our humanity" (Johnson & Cureton, 2017, p.22).

The qualities that are essential to humanity remain contested, and are often discussed indirectly in the form of values in debates on human rights, advances in medical technology, medical assistance in dying, and aging (van Trigt, Koo & Schippers, 2016). For example, in health care, discussions about the essence of what it means to be human are frequently embedded in the values of dignity and

respect for persons. The values of preserving human dignity and respect for persons reflect societal values of Canadians to the extent that they have been taken up at all levels of health care and across health disciplines as *moral imperatives*. Evidence of the importance of these moral imperatives to Canadians is reflected in legislation at a federal level—Bill C-14—and at a provincial level in the Health Professions Act in BC. The entrenched nature of societal values in social institutions is reflected in the degree of distress participants expressed when they confronted ethical violations. Examples participants described of violations of respect for persons and autonomy included when a patient was maintained in a SR for an extended period of time, or when the MHA was used to confine someone (who no longer met the criteria for certification) on an inpatient unit so that housing could be arranged.

In this discussion on *systemic inhumanity*, I identify two lines of thinking that are pertinent to the findings in this study. First, the ethical challenges participants experienced resulted from violations of moral imperatives, based on societal values, about how people ought to be treated in health care. Thus, I characterized the regularity and degree of moral violations participants experienced in acute mental health care as *systemic inhumanity*. Secondly, this underscores the need to examine the social forces that, on the one hand, create the social structures responsible for upholding moral imperatives and on the other hand, became the site of the moral violation.

Humanity and inhumanity

The influence of perspectives of autonomy on the treatment of patients. In health care, treating others with humanity refers to extending compassion, sympathy, kindness, and tenderness toward another. These ideas are captured in professional Codes of Ethics and Standards of Practice for nurses (Austin, 2011) and across health care disciplines in the language of respect, dignity, compassion, competence, and so forth. For example, Niemeijer and Visse (2016), while exploring the possibility of using relational auto-ethnography in the provision of “humane” care to persons with chronic illness or disability, equate “humane” care with the provision of “good” care.

Good care for those who have chronic illness, or a disability, means that HCPs engage in a relationship with the other, with a focus on understanding what “*matters to the people whose positions (or in fact, human-ness) are contested*” (Niemeijer & Visse, 2016, p. 170; original italics). According to these authors, good care involves extending humanity to people with a chronic illness or disability by being willing to engage in a genuine relationship with them to understand their whole experience. Niemeijer and Visse (2016) further argued that humanity, or good care, is to a degree, diminished because of assumptions about autonomy based on an idealized, rational person who is independent, or seeking independence. Left unexamined, this view of autonomy cannot account for the relational and interdependent way people with chronic illness or disability actually live (Ho, 2008). It also does not examine the way that social forces shape our understanding of autonomy (Ho, 2008). With this understanding,

inhumanity is not necessarily the act of treating others without respect or dignity, or with callous disregard or abuse, although it can be. Inhumanity is also the unwillingness of people, or broader governmental systems, to step into a relationship with someone who is constructed as vulnerable, and to genuinely understand the complex relationships that are necessary for that person to live a full life according to their desires and needs.

During data collection, I heard accounts of outright abuse of patients and staff. However, more frequently, *systemic inhumanity* was evident when participants tried to navigate incredibly complex situations, and other people with some level of organizational power in the health care system either refused to address the situation at the same level of complexity, or minimized and dismissed the problem. Several accounts from participants informed the category *struggling with inhumanity*, and related to bullying and abuse. Participants described a reluctance or refusal of middle and senior managers to address bullying or abuse of staff or patients in an effective way. In accounts of bullying between colleagues, often the person being bullied was vulnerable in some way, and when those in authority minimized or dismissed the problem, they contributed to the perpetuation of inhumanity.

An idealized view of the HCP as an autonomous agent also obscured how some societal forces, such as the discourses of scarcity and efficiency, influenced HCPs' perspective of the options for enacting moral agency. As noted above, some of the inhumanity participants had to navigate related to the complexity of the situation. For example, when participants worked in a toxic

environment, or with a co-worker who was abusive toward peers and patients, they often reported that the leadership team was aware of the situation and chose not to take action. Having said this, several participants who were part of the leadership team recounted the difficulties, and time-consuming nature, of trying to address employee performance issues due to organizational policies and procedures. Some leadership challenges included the number of agencies involved, the length of time it took to work through the process, and finally, the engagement of co-workers willing to write up and corroborate instances of bullying or abuse. Many complex requirements meant that managers seldom engaged all the elements needed to tackle bullying behaviour effectively. The result was that the HCP doing the bullying did not experience significant consequences for his or her behaviour. The process of avoiding the complexity of dealing with bullying behaviour sent several messages to staff working in the mental health programs. Those who participated in this study espoused the message that a culture of bullying would be tolerated and that they were responsible for protecting themselves, and their patients from the repercussions of bullying. It is also possible that other staff (those who were bullying) likely inferred that they would not experience sanctions.

Other illustrations that reflect inhumanity are those actions that deny the extending of a basic level of respect to the person at the center of care. One example came from the participant who spoke about staff putting food for an ED patient in a locked SR directly on the floor instead of on a paper tray because staff believed the patient could potentially use the paper tray to plug the toilet.

From a practical perspective, a HCP working in any other area of the hospital would recognize the health risks of feeding a patient food off the floor and *would not do it*. From a moral perspective, expecting a patient who is locked in a SR to eat food off the floor leads to further dehumanization of people who struggle with mental health issues. Yet, although this practice was not an official policy, it was, and remains, a common practice in the acute mental health care settings that were part of this study.

Relational Approach to Care. Neimeijer and Visse (2016) recently called for a relational dialogical approach to navigating the complexity of illness by entering into a dialogue that solicits the many sides of chronicity or disability with those we care for. The dialogical process is intended to move beyond gaining knowledge of the experience and to move toward an act that promotes growth and interdependence in both parties. Neimeijer and Visse (2016) view this process as a *praxis of care*. Although these authors advocate for a relational approach that goes beyond what is commonly practiced, the value of holding the patients at the center of care, and understanding what matters to the patients, has long been a central tenet of practice for HCPs in Canada. Recently, for example, it was elevated to importance in health care policy as the value of person-centered care (PCC)⁴⁸ at both the provincial and federal levels of health

⁴⁸ The *British Columbia Patient-Centered Care Framework* (2015) defines patient-centered care as care that “puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between

care policy (Mental Health Commission of Canada, 2012; Ministry of Health, 2014c).

In equating humane care with good care, Neimeijer and Visse (2016) clearly connect the practice of HCPs to the moral obligations they have to their recipients of care. In this study, some of the ethical challenges participants faced violated these moral obligations for humane care, and the governmental policies on expectations of PCC. When this occurred, deeply held *societal* values, as well as professional and personal values, were violated for participants. Participants were in a dual position: they were both a member of society that entrusted these values to health care organizations, and were also HCPs who had a moral and legal obligation to uphold these values.

The relational nature of agency within broader social structures. This study also supports what is known in the literature about relational agency, which is the view that individuals enact moral agency within a web of interconnected relationships (Doane & Varcoe, 2013; Baylis, Kenny & Sherwin, 2008; Rodney & Varcoe, 2012; Sherwin, 1998). In addition, it further contributes to our knowledge about the complexity HCPs face when they act as moral agents within a complicated network of relationships, such as when advocating for care and resources for patients with a DD. Taking an ecological perspective, this meant that participants advocating for patients with a DD engaged with people within the organization, outside institutions, as well as the societal structures that shape

individuals, families, and health care services providers” (p. 1).

how these relationships are lived out. Participants in this study told stories that demonstrated the relational and embedded nature of agency within the complex, layered, relationships of health care organizations as they negotiated ethical challenges. This included having to navigate the various societal structures that influenced professional practice and health care delivery.

Societal structures that influenced care. Scholars in bioethics help make our implicit understanding of humanity explicit, as they explore hidden assumptions about our beliefs surrounding autonomy and agency in healthcare decision-making (see for example, Ho, 2008; Sherwin, 1998). In thoughtfully critiquing assumptions about autonomy, bioethics scholars reveal assumptions based on beliefs that autonomous individuals are able-bodied, rational, and independent. Scholars also push their critiques further to expose how social forces that structure society, and organizations that reflect societal values, favour an idealized and unrealistic view of autonomy (Ho, 2008; Williams & Chadwick, 2012). That is the view of an autonomous agent as independent, rational, and self-interested, and whose values are transparent to himself or herself (Baylis, Kenny, & Sherwin, 2008; Rodney et al., 2013). Erroneous assumptions about the independence of agents (such as the HCPs in this research) obscure the relational complexities involved in taking moral action.

For example, professional regulatory bodies, such as the College of Physicians and Surgeons of British Columbia and the College of Registered Psychiatric Nurses of British Columbia, were established through provincial legislation, specifically the Health Professions Act, to regulate HCPs. The primary

duty of the regulatory body, which reflect a societal value, is to keep the public safe from harm that may result from incompetent or unethical professional practice. To accomplish this, the regulatory body sets minimum Standards of Practice competencies for HCPs. The practice competencies are underpinned by the values of the profession, and the professional Code of Ethics; hence, the practice competencies, and the Code of Ethics form the legal and professional obligations of members of a profession. Although the regulatory body may address the practice of individual professionals, it has little authority to address the organizational conditions under which practitioners work.

For participants, this meant that individual practitioners might be held accountable for patient safety in situations related to the conditions of the health care organization, such as overcrowding in the ED, as if their autonomous actions can be separated from the context in which they work. Although this is one example of how societal structures, through government, influence, and enact their own forms of constraints on professional agency, other examples were also evident in this study. These included the Ministry of Health's *Pay-for-Performance* initiative that resulted in shortened patient assessments.

The discourse of efficiency superseding the value of patient-centered care in decision-making. The discourses of patient-centered care and efficiency also carried oft-conflicting messages of professional obligations of care. An example of conflicting messages in the provision of health care services is seen in policy documents released by the MoH that underpinned the direction of care during the time frames for this study. In February 2014, the MoH released a

document outlining priorities for health care delivery in BC. The first of the eight priorities was the provision of patient-centered care. In February 2015, the MoH published the *British Columbia Patient-Centered Care Framework* outlining the vision and principles for patient-centered care. Behind this was a government directive to find savings throughout the health care system.⁴⁹

Although public policy foregrounded the value of patient-centered care, the message taken up by participants in this study was that there was a need to quickly move patients through acute care mental health programs in order to “find savings” through efficiencies. Several participants spoke about trying to hold patient-centered care in tension with the emphasis placed on tracking how many patients had been serviced through their program. Participants who articulated this tension and bridged the gap between their professional values and physical resources available indicated that they worked to treat all patients with respect—for example, by performing small acts of compassion such as providing snacks and making sure that, on discharge, they gave all patients available information about community resources.

The implicit uptake of the view of efficiency was particularly evident in references to the significant increase in the numbers of patients through different acute care mental health programs. Such references may be a result of the explicit application of corporate values to the health care system. For example, Austin (2011) examines the impact of corporate values in the form of a customer service model that can shift the moral community of health care to that of a

⁴⁹ Please see Ministry of Health Mandate Letter, 2013

market place community. Austin raises several concerns with corporate values and their concomitant “customer service” approach that are pertinent to this study. These concerns include the ability of language to reveal our values, shape moral reasoning, and ultimately direct our actions.

The language of efficiency, such as the standardization of services, values efficiencies that can be measured in the number of patients served. This efficiency approach can obscure the complex needs of the individual patient (Rodney & Varcoe, 2012). Efficiency from this perspective, for example, reflects patient-centered care only for those patients who fit the clinical pathways and available resources. However, the contradiction of providing care based on available resources instead of patient needs may go unnoticed because the language and actions in health care reflect the needs of corporate efficiency.

The consequence for moral agency is that HCPs do not take action because they fail to recognize the ethical implications when decision-making is based on valuing efficiency over stated health care values. Although some participants noticed this tension, many participants did not appear to recognize that policy and practice decisions were made based on the rapid flow of patients. Instead, these participants seemed to accept scarcity and lack of resources as a simple “fact of life,” not an ethical issue. One example of when participants failed to recognize the ethical implications of practices based in efficiency occurred when patients were discharged to a hotel in order to move them out of the acute care system. These patients often needed specialized housing due to

aggression, and were difficult to place. The hotel was paid for by acute care dollars, even though the patient was no longer admitted to the hospital.

Offloading Responsibility for Care, and Safety and High-Stakes Situations

Offloading responsibility for care occurred across all levels of the health care system and between government ministries. Within the acute care system, examples of *offloading responsibility* occurred between departments or between different levels of the hierarchy. A common account I heard involved the tension between the medical and psychiatric departments about which department was responsible for providing care for a patient with a combination of medical and psychiatric issues. In stories that involved bullying or professional incompetence, participants tended to say that the person above them in the organizational hierarchy was responsible for addressing the problem (which I will discuss further in the section on leadership in this chapter). In this section, I discuss accounts about situations of *offloading responsibility* among government sectors that were pervasive in the data, because the practice resulted in significant safety risks and high-stakes situations. Participant narratives about care provision for patients with serious mental health issues were further complicated by patient needs related to diagnoses of intellectual disability (ID) or forensic histories. In these instances, HCPs were left with the responsibility of organizing housing and social supports for these complex patient groups. At the time of writing, these narratives

were also reflected in the local news.⁵⁰

Some of the sociopolitical elements that influenced offloading responsibility for care across sectors include deinstitutionalization, insufficient funding and collaboration across sectors, as well as the criminalization of mental illness (Livingston, Nicholls & Brinks, 2011). Dealing with the complex ethical challenges of these patient groups exposed the necessity of working collaboratively across sectors in order to address the social influences that impacted patients with multiple layers of vulnerability (BC MoH, 2013; CAMH, 2013). Furthermore, the diagnosis as well as the behaviour of these patients made them more or less palatable to participants, affecting the level of risk participants would, or could, take on behalf of the patient. For example, some participants reported that in some situations, a hospital was mandated to care for an aggressive patient until a bed in a forensic or tertiary facility became available. When this happened, participants were constrained in what they could advocate for. Participants' willingness to *risk vulnerability* depended on the degree of vulnerability they attributed to the patient, held in tension with their perception of their professional obligation for the patient. For example, participants identified that patients with a forensic history and a diagnosis of antisocial personality disorder (APD) contributed to the increase in frequency and intensity of violence in acute care mental health, while some patients with an ID were at risk for serious harm, and even death, if discharged without appropriate housing and

⁵⁰ Please see, for example: <http://vancouversun.com/health/local-health/what-to-do-about-kyle-health-care-system-has-no-place-for-paralyzed-mentally-ill-and-drug-addicted-man>

supports.

Increasing violence and antisocial behaviour. I focus on patients with a forensic history in this section because participants named this population group when discussing the ethical challenges related to violence. Nonetheless, participants also acknowledged that aggression was not limited to this population group, however, they generally agreed that this population was responsible for much of the increased violence they witnessed and experienced. In some situations, participants described aggressive behaviour as purposeful, designed to get the patients what they wanted. Participants also distinguished between patients with an APD and other mental health diagnoses. Several participants noted that a patient with a diagnosis of APD could not be helped on a general psychiatry unit, especially when the patient was violent; instead, treatment was geared toward behaviour management. This meant that, if a patient posed a high risk for violence, they were maintained in the SR until discharge, which could be several months.

These situations raised high levels of ambivalence in participants, because they experienced anxiety at the very real possibility of being hurt or of witnessing harm to another. At the same time, participants struggled with the inhumanity of keeping an individual locked in a SR for several months. This ambivalence had ramifications for moral agency and what participants were willing to advocate for in these cases, because they were torn between the desire for safety and their desire to extend dignity and respect to another human being. This problem was exacerbated in acute care because the physical environments

are becoming increasingly inhospitable due to overcrowding. On some units, spaces used as alternatives to SRs, such as quiet areas for de-stimulation, were being converted to patient rooms. On other units, two-bed rooms were being used as three-bed rooms and four-bed rooms as five-bed rooms. During this study, options for safe spaces, aside from SRs, were disappearing, placing constraints on participants' agency by limiting what they could advocate for.

In situations involving patients with an ID, participants advocated for stable housing and discharge supports that would allow the patient to live as safely as possible in the community. In some cases, this meant keeping the patient for an extended period of time until these resources were in place; participants, then, were willing to take more professional risks by speaking up, or pushing back against systemic practices of discharging patients to a hotel or shelter once they were stable. In contrast, in situations with a patient who had a forensic history coupled with a diagnosis of APD, and a history of violence, participant advocacy was directed at protecting others from the patient by pushing for increased security on the unit and moving the patient back to the forensic system as quickly as possible. Several participants discussed the need for greater information sharing with the local police as a means of decreasing the risk for violence in health care settings. Only one participant raised concerns about the patients' right to confidentiality or increasing police involvement in mental health care. This indicated that fear of aggression by the patient superseded concerns about the criminalization of mental illness (Boyd & Kerr, 2016; Mollerhoj, Stolan, & Brandt-Christensen, 2015).

The ambivalence felt about forensic patients' care in a general psychiatric unit is also reflected in the literature. Mollerhoj, Stolan, and Brandt-Christensen (2015) conducted qualitative research that included nurses and managers. These researchers wanted to understand why caring for forensic patients in general psychiatry was experienced as a burden by direct care staff and managers. Their findings highlighted five themes, some of which mirrored concerns expressed by my participants. The shared concerns included concerns about the physical environment not being suitable for taking care of patients long-term, because there was no capacity for the patient to get any exercise or to go outside, due to lack of secure space. There was poor cooperation across sectors, along with poor communication, which resulted in long waits for agreements to be signed, as well as for services, such as, housing. Also, as discussed above, staff expressed a fear of aggression because they often felt threatened by the patients in their care. Finally, participants noted the energy expended in working with people with personality disorders and antisocial behaviour, because these patients' thinking and behaviour were not easy to correct due to the threat of violence.

Worthy and unworthy mental health patients. Perhaps one of the most telling findings in the study by Mollerhoj, Stolan, and Brandt-Christensen (2015) was that of the nurses' inability to identify any therapeutic interventions, beyond giving medication, that might be helpful to the forensic patient. Instead, they viewed the primary issue with this population group to be their criminal behaviour. This meant that once the patient's mental health symptoms were

treated with medication, the patients were viewed as a “bed blocker”: a patient who takes up a bed that could be given to a patient who had a serious mental illness. The authors point out that this perspective contributed to unspoken assumptions that made a distinction between patients who were worthy or unworthy of mental health care. This was also evident in the interviews where there was an unspoken assumption that some patients were worthy of care and others were not, especially in relation to substance use and those with a forensic history of violence.

This distinction was also evident in some of my research interviews, when participants contrasted criminal behaviour that resulted from substance use and criminal behaviour that resulted from an APD.⁵¹ One participant used the term, “medicalizing” criminal behaviour, to describe the police practice of bringing apprehended individuals with APD to the ED after a criminal event. Participants expressed more compassion for forensic patients with a concurrent substance use disorder, and pointed to the need for harm reduction, greater access to treatment beds, and social supports in the community, such as stable housing. However, patients with APD were viewed as being non-treatable.

⁵¹ Several participants singled out patients diagnosed with APD as being responsible for much of the increase in aggression. Participants identified the aggression from this population group as intentional, designed to get the patient’s needs met. Participants noted that patients with APD lacked empathy, and as such were untreatable because the patient could not form an emotional connection based on the needs of the other person, in this case, the need of HCPs and other patients to be safe. The consequence was that participants did not view a person with APD needing a hospital setting; instead, they believed the patient ought to be taken directly to jail.

Deinstitutionalization and reinstitutionalization through the criminalization of mental illness. Several participants suggested that the deinstitutionalization and the closure of the Provincial Psychiatric Hospital were partially responsible for the shifting population demographic they observed within the acute mental health care system. Participants spoke about how the Provincial Psychiatric Hospital historically served as a buffer between the acute care hospital system and the Forensic Provincial Hospital (FPH), by admitting forensic patients when FPH was full. They believed that the closure of the Provincial Hospital exacerbated the gaping lack of infrastructure in place for individuals with a combination of criminal behaviour and mental disorder. There is support in the literature that, when poorly planned and insufficiently funded, deinstitutionalization leads to transinstitutionalization⁵² and poor health outcomes for patients (Livingston, Nicholls & Brink, 2011; Morrow et al, 2010).

⁵² Transinstitutionalization refers to the unintended negative consequence of deinstitutionalization that can occur when people with a mental disorder are admitted to other institutions, such as the criminal justice system, that are unable to appropriately address their mental health needs (Livingston, Nicholls, & Brink, 2011).

However, the factors that contribute to the perceived⁵³ increase in the admission of forensic patients are intertwined with a growing awareness on the part of policy makers of the interconnection between mental illness and criminal behaviour. Participants stated that increased understanding that mental illness may be a contributing factor to criminal behaviour meant that people who engaged in criminal behaviour were sometimes brought to the ED instead of to the jail.

Other elements that add to increased admission of forensic patients include the deinstitutionalization movement in Western countries, and complex social factors such as stigma, race, gender, and socioeconomic factors that contribute to the criminalization of mental illness (Boyd & Kerr, 2016; Livingston, 2016). Some common features that contribute to the failure of deinstitutionalization are poor planning, insufficient funding, divide between psychiatric symptoms and social care, lack of community capacity, and lack of

⁵³ I use the word *perceived* because post data collection, I tried to confirm participants' anecdotal experience of the increase in admission of patients with a forensic history or with an DD with data from the *Canadian Institute for Health Information* (CIHI). Through negotiations with a representative from CIHI, I found that admission and discharge rates from mental health units for patient with a forensic history or ID was not tracked consistently across health authorities locally or provincially. Although representatives at CIHI were willing to gather what data was available, I did not pursue this option due to cost, time constraints, and the potentially uneven quality of the available data. The uncertainty of gathering accurate and complete information about the impact of deinstitutionalization made it difficult for me to support the subjective experience of participants with objective data. Lack of consistent data on these two population groups also indicates that, at a population level, we do not have an accurate picture of what happens to these individuals when they are released from jail or discharged from hospital.

attention to the broader socioeconomic factors that impact mental health, such as stable housing, and social connectedness (Livingston 2016; Livingston, Nicholls & Brienk, 2011; Morrow et al. 2010). Yet, there is also evidence that supports positive outcomes, such as social connectedness and increased independence, when deinstitutionalization is well planned and sufficiently funded in the community (Livingston, Nicholls & Brienk, 2011; Morrow et al. 2010; Petersen et al., 2013). More specifically, several groups of researchers have followed patient outcomes since the final phase of the closure of the Provincial Psychiatric Hospital, and report that there is little evidence of transinstitutionalization (see Livingston, Nicholls & Brienk, 2011; Morrow et al. 2010; Petersen et al., 2013). Having said this, all the researchers I have cited in this analysis acknowledged that sufficient planning and funding is foundational to the successful relocation of patients to the community.

A social factor that might have influenced participants' perspectives in relation to forensic patients included a concurrent negative narrative about the problems that result from deinstitutionalization. The local police department published a series of negative reports chronicling the increasing mental health crisis that resulted from the closure of Provincial Psychiatric Hospital. Underpinning these reports was an unspoken assumption that police engagement should be limited in incidents involving people with mental health issues. This assumption demonstrates, among other things, a lack of understanding of the interconnection between the social issues that contribute to mental health and criminal behaviour.

Boyd and Kerr (2016)⁵⁴ conducted a critical discourse analysis on these reports, including police recommendations such as increasing surveillance and control, and the re-institutionalization of mental health patients. They found that the reports gave vague and selective information about the danger the mental health patients posed to the community and potentially contributed to the stigma and discrimination experienced by this population (Boyd & Kerr, 2016). These police reports have had significant social and political influence on the public perspective of deinstitutionalization, and the recommendations suggested by the police were uncritically relayed by many of my participants. Thus, it is possible that these police reports may have contributed to participants' unconscious categorization of some mental health patients as being unworthy of care.

Interestingly, while participants were quick to point to the closure of the Provincial Mental Health Hospital as one cause for the increased numbers of forensic patients in the acute care system, none mentioned the closure over 20 years ago of the last provincial institution that took care of the population with an ID. Although it is difficult to find concrete information about the transition of these residents to the community, within six years, the provincial government laid the foundation for the establishment of a new Crown Corporation, to provide support

⁵⁴ For a full critique of the police reports, readers are directed to Boyd & Kerr's article: Boyd & Kerr, 2016. Policing 'Vancouver's mental health crisis': A critical discourse analysis. *Critical Public Health*, doi: 10.1080/09581596.2015.1007923)

and services for adults with ID and those with a DD⁵⁵ (Friedlander, 2006; Tang et al., 2008). The Crown Corporation was fully established in 2005, and for the past 12 years, has been responsible for providing supports and services to this population.⁵⁶ My assumption is that this institution, in a way similar to the Provincial Psychiatric Hospital, served as a “catch-all” for difficult-to-manage children with behavioural or cognitive issues. Once the institution closed down and a government ministry was established (with a narrow mandate⁵⁷), it was revealed that there was inadequate infrastructure in place for people who need support but do not meet the new, narrow criteria for care (Tang et al., 2008). This population faced the same obstacles that confront all marginalized groups. However, without the cognitive capacity to advocate for themselves, they were left at a higher risk for exploitation, mental health issues, and substance abuse.

Many of the patient situations shared by participants revealed the uptake of responsibility for providing care for patients who, until recently, fell outside of the primary mandate of acute mental health care. Examining some of the

⁵⁵ Dual diagnosis (DD) refers to individuals who have an Intellectual Disability with a concurrent mental health diagnosis.

⁵⁶ For details, see <http://www.communitylivingbc.ca/about-us/history/>

⁵⁷ When the CLBC was first established, their mandate was to provide community living support and services to children and adults with developmental disabilities. The definition of developmental disability was “measured intellectual functioning of approximately 70 IQ or lower, with onset before age 18, and measured significant limitations in two or more adaptive skill areas” (CLBC Service Plan, 2005/06 – 2007/08). In 2010, CLBC’s mandate expanded to include adults diagnosed with Fetal Alcohol Spectrum Disorder (FASD) or Pervasive Developmental Disorder (PDD). (CLBC Service Plan, 2010/11 – 2012/13).

elements that influence the shifting demographics of acute mental health care patients, such as deinstitutionalization and revised mandates, reveals multiple examples of how government ministries offloaded their responsibility to provide care for specific population groups. As well, an increasing, and uneven, awareness of the contribution of mental health to criminal behaviour, resiliency, and capacity building may impact the emphasis professionals place on mental health treatment when they are presented with a person who has a constellation of complex issues. An example of this was seen in my study in terms of decision-making with regard to what system might best serve the needs of a person with a forensic history, or a patient with DD and concurrent substance use.

Direct Care (DC) staff overseeing care and discharge planning experienced disconnection from those with financial responsibility for the discharge resources. In situations involving patients with a DD or a forensic history, participants did not have direct access to decision-making tables; instead, information was passed on through organizational channels. These participants described following organizational procedures (e.g. filling out the appropriate paper work), yet not knowing if the information was getting to the right people or if the information was being interpreted appropriately.

In a few of these situations, participants described how they enacted moral agency relationally, by going to their program leadership and asking to attend these meetings, in order to provide information directly. Even if no tangible decision or resources were provided, participants described these meetings as helpful, because they were able to contribute information patients deemed

important (patient-centered care), and network with people who would have a direct role in determining discharge resources for the patient. Often, leadership was hesitant to allow the participant to attend these meetings, because it meant the DC staff would be taking time away from being on the unit providing direct care. In this situation, the participant *struggled with inhumanity*, having limited avenues and support for advocacy and directed their efforts toward developing a therapeutic relationship to provide a space for the patient's voice to be heard.

Those who work in the acute mental health care system are also complicit in *offloading responsibility for care*. For example, and as noted earlier in this Dissertation, during my time of observation, I witnessed an identified forensic patient being discharged to a hotel room. The patient had been barred from all shelters due to incidents of violence, and the patient was deemed too unpredictable to go to a mental health boarding home. The acute mental health care program paid for the hotel bill, and the assumption was that a community mental health team, with responsibility for finding placements for hard to place patients, would find appropriate placement for this patient within two weeks. The participant described this situation as an ethical challenge because the possibility of placing this patient in any of the established resources was slim. However, the result of discharging the patient meant that they were no longer the concern of the acute care program, even though acute care dollars were paying for the hotel. The situation was also potentially unsafe for the patient and the public. This was an example of *offloading responsibility* on to the community mental health program, while the participant disagreed with the practice; s/he

rationalized the practice based on the need to move the patient out of the bed.

I also witnessed and heard about patients being diverted out of inpatient care, regardless of their need for care, because of their presenting diagnosis or history of diagnosis, such as substance use or a forensic history. The discourse of efficiency underpinned some of these actions, and a few direct care staff boasted about saving money or time by diverting potential patients from the ED or possible admission.

The discourse of efficiency and scarcity of resources underpinned *offloading responsibility for care*. For example, the discourse of scarcity permeated discussions about insufficient planning and funding for deinstitutionalization, lack of collaboration and communication between sectors for complex mental health populations. As well, the discourse of scarcity and efficiency contributed to the unspoken identification of certain patients with mental disorders as being unworthy of care, such as people with a history of substance abuse. Ultimately, one of the consequences is that the acute care mental health system has taken up responsibility for attempting to provide services for progressively complex patients. As evidenced by several stories of patients with ID being kept in acute care mental health programs for extended periods of time until appropriate housing could be arranged.

Political and Policy Tensions and the Influence of the Context of Care

What was evident in this study was that the enactment (or attempted enactment) of moral agency happened relationally at all the levels at which

participants worked. Relational elements such as organizational culture, strength of organizational policies, qualities of the direct supervisor, and social connections within the organization all influenced the extent to which participants believed they could act, along with the avenues of action open to them. In this section, I discuss the influence of leadership and teams on moral agency. It is important, however, to first address the contradictions or tensions between competing values or the fact–value split in the enactment of policy that contributes to *systemic inhumanity* and *offloading responsibility for care* before discussing these influences. This is largely because participants pointed to these contradictions as playing a significant role in their own decision-making for taking action.

Values versus cost. The first tension occurs within the provincial government, in the dual role of setting policy direction for health care while setting financial parameters on health authority spending. I understand this dual role as a separation between the actual cost of health care and the values of health care, or a fact–value split. In BC the value of the provision of patient-centered care is held in tension with strategies for cost containment. An example of this tension is evident in MoH policy documents such as *Setting priorities for the BC health system* (MoH, 2014), which lists the first priority as the need to “shift the culture of health care from being disease centered and provider focused to being patient centered” (p. 3). Fiscal responsibility is not listed as a priority, however, improved cost management is listed as a strategy to drive successful change (p. 6). Although public documents from the MoH prioritize societal values

such as patient-centered care, in policy documents, often the source of ethical challenges raised by participants was a result of fiscal constraints on resources.

This sometimes resulted in organizational practices intended to create greater efficiency in a drive to decrease costs, which contravened patient-centered care. The outcome was that leadership decisions at different levels of the organization were consciously or unconsciously based on efficiencies and cost controls, superseding PCC. Organizational leadership were not the only people to do this; many participants framed their response to ethical challenges in the context of balancing professional values against the actual cost of providing care that aligned with these values. Many participants also acknowledged that decisions about resources, admissions, discharges, and deflecting patients from acute inpatient services were driven by costs, yet only a few participants connected these decisions to contributing to the inhumanity patients experienced. Participants who did specifically identify some of the practices based on reducing costs as inhumane and as a source of ethical issues, attempted to mitigate the impact on patients through acts that humanized the patient. This included actions, such as taking more time to listen to the patient, getting them a warm blanket, or obtaining extra food for them.

Hollow policy. Participants observed that there was a lack of political will to enforce some organizational policies, such as bullying policies. Accounts of staff and patient bullying pervaded the data in this study, although most participants acknowledged the presence of zero tolerance policies and resources within their organizations. Many participants referred to these policies as “sham,” “hollow,” or

“ineffective,” stating that the organization or their direct supervisor tolerated negative behaviour, and in some cases, were the source of bullying. Participants viewed and used policy in different ways, depending on their social position within the institution. Participants further away from the provision of direct patient care tended to speak about drawing on policy to support their moral agency. In contrast, the majority of participants providing direct patient care expressed that they tended to view policy on bullying as an organizational façade, and felt isolated in their attempts to uphold ethical practice by drawing on policy. This meant that participants providing DC looked to peers or mentors for support in practicing in a way that aligned with their professional obligations, instead of using policy to support action.

The tensions outlined above mirrored the *is/ought gap* that formed the background for the ethical challenges participants had to navigate. As discussed in Chapter Five, the *is/ought gap* refers to the fact–value distinction, and the need to find a way to bridge the divide between facts and values. Many participants did find a way to bring together facts and values about ethical practice, albeit often in less than satisfactory ways. Organizational leadership and the immediate team a participant worked in had the power to shape a participants’ experience of enacting moral agency in ways that ranged from empowering to constraining. Participants then carried the lessons learned from these different experiences into subsequent ethically challenging situations.

The Role of Leadership

In this study, I noted that participants made assumptions about individuals in positions of leadership and the organizational authority that accompanied the leadership position. Participants identified the person they reported to as their direct supervisor and attributed a certain amount of organizational power to that person. The assumption about formal, organizational power was evident in the subcategory of *distancing self*, when participants spoke about seeking positions away from the provision of direct care in the hopes of having some authority to create change in the way care was delivered. Participants often overestimated the level of organizational authority or power that was attached to different positions. For example, DC staff assumed that the person in the DC2 or ED2 position had the authority to sanction a colleague that exhibited bullying behaviour. This meant that at times, participants assumed the person directly above them in authority had more power to effect change than was actually true. This assumption contributed to *offloading responsibility* within the health care organization, because participants assumed that if they reported an ethical issue to someone with more organizational authority, they were no longer responsible for addressing the problem, and that somebody else was.

Offloading responsibility also worked in the opposite direction. At times, those with institutional authority to enforce policy delegated responsibility for action to the person below them in the hierarchy, even if that person did not have the organizational authority to act. One participant described a situation that involved significant employee performance issues. Senior leadership chose to

pass responsibility for taking action down the hierarchy to the participant, who did not have the organizational authority to take the appropriate actions. In this situation, the participant took action by turning to the regulatory body. As participants moved up the organizational hierarchy, they gained depth of insight (political knowledge) into the organizational hierarchy and the amount of power/authority connected to each position.

The Influence of Leadership on Moral Agency

There is a substantial, and growing, body of literature on the role of leadership in the provision of quality health care. Researchers have pointed to the important role organizational leadership has in influencing the ability of HCPs to provide care that aligns with their professional obligations (Gabel, 2012; Orchard and Morse, 2017). Leadership influence extends vertically and horizontally through the development and enactment of policies, resource distribution, collaborative relationship-building, and mentoring (Orchard et al., 2017; Udod, 2012). Although the present study was focused on enacting moral agency, it contributes to our knowledge on leadership practices that empower HCPs when they seek to understand and develop their capacity as an ethical practitioner (Gaudine & Beaton, 2002).

People in leadership positions have the opportunity to support growth as a moral agent. For example, Udod (2012) conducted research on nurse empowerment and the use of power in the nurse-manager relationships. Udod (2014) found that nurses sought connection with their managers because they

believed that these connections would enable them to provide high-quality patient care. When managers focused on organizational priorities such as meeting the budget and enforcing policy, they effectively cut themselves off from communicating with nurses. The result was that nurses perceived that they were isolated from the support and resources necessary to provide quality care.

Some nurses described how their managers disconnected from direct care staff in order to fulfill organizational role obligations. Managers created further disconnection from nurses by using silencing forms of communication that restricted dialogue and support between management and direct care staff. Nurses responded by resisting changes brought in by the manager and acting collaboratively to promote change through becoming confrontational with the manager (Udod, 2014). However, when nurse managers directed their attention away from organizational priorities, such as focusing on cost, and onto nursing, nurses perceived that they had more control over their practice. Thus, they viewed themselves as more confident in providing care (Udod, 2014). When nurses experienced managers who connected with them as collaborators in care, these managers re-established a pattern of connection between nurses and managers. One of the results of managers connecting with nurses was an increased sense of trust in organizational management.

The findings in this research add support to Udod's (2012) findings, and raise further questions about the influence of a manager on direct care staff. Trust is based on the organizational leaders' capacity to act in ways that reflect stated organizational, professional, and societal values. In this current study, the

manager's leadership style had consequences for how participants enacted their moral agency. Participants who experience support from their manager also described feeling empowered to take action, and describe a greater range of options for taking action.

The participants in this current study who had a realistic view of the role of their supervisor, as evidenced by recognition of the structures that influenced decision-making, were more likely to take responsibility for their own moral agency beyond simply expecting their immediate supervisor to take action. Taking responsibility for moral agency was evident in participant stories that informed the categories of *pushing back*. Participants who *pushed back* recognized the structural elements that influenced policy and decision-making. They had also developed knowledge of the political structures in the organization, as well as knowledge about the potential consequences of their agency. They recognized the advantages of forging relationships with other HCPs across disciplines and programs, or with HCPs who were in positions of influence within the organization. They sought mentorship relationships that would help them navigate challenging situations, and they looked for ways to be supportive (and receive support) from their immediate team and management.

Participants, who viewed program leadership as ineffective or as uncaring, did not trust leadership to take any action on ethical issues. When staff members repeatedly experience lack of leadership action in unethical situations such as bullying, they lose trust and describe their leaders and their organizations as “uncaring” or “toxic” (Vickers, 2012), which are descriptors I heard in several

interviews. In this study, the participants' descriptions of feeling isolated when considering how to address ethical challenges informed the category of *struggling with inhumanity*. Many of these situations involved bullying or a failure to extend overall respect, compassion, and dignity to patients, or staff. These participants turned to select peers or mentors from within the profession but outside of the team, as they saw themselves as having no viable options for support within the organization, which I describe below.

Leadership and Policy

In this study, I included participants from across disciplines and at various levels of care delivery. I noted that when participants from nursing spoke about going to their supervisor or leadership, they were referring to the person directly above them in the organizational hierarchy. Most often, this was someone in a DC2 position. Many of these participants did not know who their manager was or had never met the manager. In both organizations, I noted a distinct disconnect between the experience of members of the leadership team and the experience of direct care staff.

The leadership team was made up of people who worked in DC2 or ED2 positions and were responsible for the day-to-day running of the unit and for staff needs. They also had a supervisory role, although not a disciplinary role, over the staff. Some members of the leadership team described a collaborative working relationship with the program manager, with information sharing, effective communication, transparent discussions about ethical issues, and a sense of

personal caring from the manager—all of which have been identified as key components of empowering nurses (Regan, Laschinger, & Wong, 2016; Udod, 2012). Participants on the leadership team, who talked about trusting their manager, also spoke about having regular, meaningful contact with him or her that involved discussing a balance of organizational concerns along with clinical practice concerns. These participants also shared that they felt they could raise ethical concerns with their manager because these concerns would be taken seriously. This, in turn, led them to feel respected as a professional and empowered to *risk vulnerability* when ethical concerns arose.

In contrast, participants working in DC positions in these same programs regularly described their manager and leadership team as ineffective and not helpful in ethical situations, particularly in situations of bullying. This finding raises questions about the disconnection between the experience of support for those in leadership positions and the experience of lack of support for those working in DC positions. Specifically, the question is: how do people in leadership positions effectively convey a sense of support and meaningful connection, across several layers of organizational hierarchy, in order to impact positively the HCPs providing direct care, when they confront ethical challenges?

The Influence of Leadership Support in Situations of Unsafe Practice and Bullying

Stories of negative behaviour and bullying between colleagues and from managers permeated the data. This was not surprising, given the increasing

awareness of the impact of bullying on HCPs and the possible connection to patient outcomes (Hurley, Hutchinson, Bradbury & Browne, 2016; Hutchinson & Jackson, 2013; Pickering, Nurenberg, & Schiamberg, 2017). Yet, within health care overall, there is a growing recognition that negative behaviour and bullying are organizational problems and are not just located at the level of the individual; as such, organizational leadership has a significant role in addressing these behaviours (Hurley, Hutchinson, Bradbury & Browne 2016; Joint Commission, 2008).

Recommendations for addressing workplace violence available in the sites that I studied included the introduction of policies designed to address bad behaviour and support respectful work environments (Joint Commission, 2008; WorkSafeBC, 2013). However, one of the findings from research is that employees perceive these policies as a sham that may even protect perpetrators instead (Hurley, Hutchinson, Bradbury & Browne 2016; Vickers, 2012).

Researchers studying the link between mental health and workplace bullying identified five themes related to responses to bullying (Hurley, Hutchinson, Bradbury & Browne, 2016). One of the themes particularly pertinent to the finding of this study was mistrust in organizational responses to bullying. Hurley, Hutchinson, Bradbury and Browne found that mistrust in the organization, or a belief that the organization would tolerate bullying and protect the perpetrator, were predominant themes in narratives from their participants. My participants echoed this belief, and several (from both study sites) told stories of how the perpetrator was promoted to supervisory positions. These actions perpetuated

participants' beliefs that organizational policies directed at creating a respectful workplace were a sham (Vickers, 2012).

Research studies conducted in bullying health care environments have found nurse reports of emotions such as disbelief, anger, disappointment, and powerlessness (Hurley, Hutchinson, Bradbury & Browne., 2016; Pickering, Nurenberg, & Schiamburg, 2017). The most common expressions of feelings I heard from participants in this study were, disbelief that HCPs would bully and still be tolerated by the organization, and a sense of powerlessness. This was compounded by a sense of helplessness to take action, because organizational leadership appeared to be reluctant to address the bullying behaviour in a meaningful way.

The last theme identified by Hurley, Hutchinson, Bradbury and Browne (2016) that particularly resonated with my participants' situations was the experiences of abuse and the effective use of power. The authors reported hearing a few stories of individuals with institutional authority who used their authority to address bad behaviour and bullying in a positive way. Furthermore, Hurley, Hutchinson, Bradbury and Browne noted that when individual HCPs used their own personal power to address bullying, the behaviour stopped. Similarly, a few participants in my study identified incidents where someone in a leadership position, or one of the staff, used their power to address bullying behaviour in a way that aligned with organizational policy. One participant talked about how nurses at the unit level worked collaboratively, and exercised their collective power to address the bullying behaviour of their direct supervisor. Although these

same nurses succeeded in pushing back against bullying from one individual in a power-over position, they also experienced significant negative consequences from a more senior leader. The result was that these nurses felt unsafe and believed that they had no further recourse

Unit managers are often charged by their organizations to address bullying behaviours. To address bullying, the Joint Commission (2008) recommended that managers receive education and coaching in “relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution” (p. 2). Yet Vessey et al. (2011), noted that there is little evidence that organizational leaders have the tools to thwart negative and bullying behaviours. An added complexity, noted by participants in this study, are the multiple systems (e.g., Human Resources, unions) that must be navigated when dealing with a bully.

The manager’s response to bullying had an influence on participants’ perception of options available to them. In the situation where the manager took steps to address unsafe behaviour, the process took place over a one-year period of time. The effort required a collaborative and relational approach with the union, Human Resources, and the Clinical Nurse Education. Part of the process included taking the time to build trust with the direct care staff and framing the process as constructive as opposed to punitive. The result for the participant was that they believed the leadership within the organization had integrity with respect to their stated values. The participant also described feeling empowered as a moral agent to advocate for practice that aligned with

professional values, believing that the organization would respond positively.

Conversely, participants who stated that they worked in a toxic culture or one where the leadership in the organization was aware of bullying and tolerated it, spoke about being powerless to change the environment and, thus, took actions to protect themselves in, what they viewed as, a hostile environment, at the same time maintaining as ethical a practice as possible. Some of these participants admitted that they felt that they did not provide the patient care they believed they ought to provide; however, they believed that they were providing the best care they could within a hostile work environment. This finding mirrors other research on ethical decision-making and working in a toxic environment (Lutzen & Schreiber, 1998; Pickering, Nurenberg, & Schiamberg, 2017). In research on bullying with certified nursing care aides (CNAs), Pickering, Nurenberg, and Schiamberg report that, in toxic environments, CNAs took actions to protect themselves from bullying by minimizing their exposure to harm. These actions included work arounds, avoidance, reprioritizing care, and remaining silent, and often came at the expense of the resident's safety. The result of working in toxic environments was that the CNAs reconciled their expectations of the care they provided, which means that they were aware that they provided less than ideal care, putting residents at risk for potential risk for harm.

Negative behaviours and bullying have been connected to patient outcomes by researchers (Becher & Visovsky, 2012; Joint Commission, 2008; Vessy, DeMarco and DeFazio, 2011). Some negative behaviours witnessed and

experienced by participants in this study included non-verbal innuendo, verbal affronts and threats, including insinuations about colleagues' clinical practice. These bullies extended many of these behaviours to patients they believed "didn't need care." Patient safety incidents are regularly recorded in health care organizations' learning management systems. When patients are bullied, is this information recorded in these systems? Little evidence exists that demonstrates that staff regularly document bullying behaviour of patients as safety incidents. Without this documentation, bullying remains undeclared, and unmanaged.

Team Influences on Moral Agency

Current literature and policy on health care service delivery highlights the importance of multidisciplinary teams as central in the evolution of effective service delivery (MoH British Columbia, 2014, *Setting priorities for the BC health system*; Orchard et al. 2017). There is a global emphasis on collaborative practice as the primary mode of health care delivery (WHO, 2010). According to the World Health Organization, collaborative practice occurs when "multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (2010, p.13). All participants in this study worked in settings that delivered care through interprofessional teams, and reported on how different teams worked to either support, or constrain, moral agency.

Participants regularly reported being affiliated with more than one team in

their organization. For example, social workers were part of the unit team and provided direct care to patients, however they were also part of, and received, clinical supervision from the social work department. Several participants spoke about the importance of having their disciplinary perspectives to share during interdisciplinary team meetings. In this study, participants seemed to use discipline-specific team members to help them find their ethical boundaries and clarify their ethical perspectives. They could then return to their interdisciplinary teams with a better distinction of their ethical stance on patient cases. When the ethical challenge occurred over an extended period of time, participants used the disciplinary team for ongoing support.

Participants from the disciplines of social work, medicine, and occupational therapy had regular discipline-specific meetings (or opportunities built into the institutional structure for regular meetings) that included clinical supervision. Nursing was the only discipline that did not have time built into their schedule to discuss clinical or ethical issues from a disciplinary perspective. This may be because clinical supervision for nurses is not common in Canada, although evidence supports the positive impact of clinical supervision for professional accountability, the development of knowledge and skills (aspects of professional identity), and in providing emotional support (Brunero & Stein-Parbury, 2008). It may also be because there is an assumption that taking up the professional identity of a nurse occurs simply by being on the job in the presence of other nurses. In fact, some nurses spoke about taking the time on the unit to intentionally talk about how to provide care to particularly difficult patients.

However, these conversations were not the norm, and did not generally involve discussions about ethical practice; rather, the discussions were directed at the logistical planning of care.

One nursing participant in a leadership position spoke about starting a “grassroots” clinical supervision group with other nurses in the same position at other acute mental health care units. The group started out by discussing common professional practice issues, then shared experiences and solutions. The participant articulated the benefits of sorting through practical and ethical issues, and the support they gleaned from this group. In the end, senior management disbanded the group, claiming they wanted more leadership presence at the different sites. The message communicated to the participant and subsequently relayed to me was that nursing concerns did not matter and that senior management did not trust people they put in leadership positions. As a consequence, this participant believed that they worked in isolation. They experienced a high degree of stress coupled with a lack of management support, and began to plan an exit strategy from the organization.

Two psychiatrists participated in this study; it is worth noting physicians had a different relationship with the hospitals, because they were not employees of the system. Physicians overall also had more power because they ultimately held the responsibility for admitting and discharging patients; at times, physicians used this power to navigate ethical challenges. Nonetheless, my intention here is not to minimize the physicians' experiences, because they clearly identified ethical challenges and acknowledged experiencing moral distress. One of the psychiatrists acknowledged that the weight of the responsibility of having to balance the competing needs of vulnerable patients, and navigate limited resources ethically, meant that they lived with the experience of moral distress.

Above, I have discussed how discipline-specific meetings could foster the development of a professional identity that included a greater depth of understanding of professional obligations and strategies for navigating ethical challenges. Participants in this study identified being members on more than one team (i.e., discipline-specific, inter-professional). In being part of both teams, several of these participants were able to articulate their perspective within the context of caring for the whole patient. When participants worked in teams that embraced a collaborative approach to patient care, participants were able to bring their ethical concerns to the inter-professional team.

All participants discussed how the functioning of the inter-professional team influenced their capacity to practice in alignment with their professional obligations. In the literature, antecedents for collaborative practice include (but are not limited to) information sharing, good communication, participatory

decision-making, mutual trust, awareness of roles and scopes of practice, and organizational supports (Horsfall, Cleary & Hunt, 2010; Virani, 2012). Collegial relationships between nurses and physicians are also part of quality work environments and collaborative teamwork (Hanrahan, Aiken, McClaine & Hanlon, 2010; Tang, Chang, & Zhou, 2013). In this study, most of the hostility between colleagues happened laterally--between nurses--or vertically--between managers and direct care staff. Some participants spoke about taking moral action by actively forging collegial relationships with physicians on shared patient issues, or by demonstrating their competency. I only heard one story about conflict with a physician, and in that account, the clinical director, a psychiatrist, took steps to facilitate a reparative conversation.

Participants who described working in teams that reflected the attributes described above, also spoke about being able to navigate ethical challenges with their team. The attributes of quality work environments informed the category of *working through team relationships*. Although members of each discipline may have different perceptions of how to practice according to their professional obligation, the participants who could “live with” their level of moral distress were those who worked in teams that were willing to explore ethical issues together. In these teams, participants described having time formally in team rounds to entertain discussion about what was actually going on in the situation, who was going to be part of navigating the issues, and suggesting how to navigate the situation, even if they did not see it as an ethical issue.

All participants working directly with patients spoke about “doing more with less” or having to “dance faster” due to increasing patient load, inadequate staffing, space, and community resources. About half of the participants described working on inter-professional teams that were able to address ethical challenges to varying degrees. However, participants who described experiences of bullying as part of the inter-professional team were more likely to admit feeling like they were working in isolation without support or opportunities for change. Many of these participants admitted that they worked casually so they could take a break from the team when it got too stressful. Participants’ enactment of their moral agency was at least partly directed at balancing their own safety—for example, avoiding becoming a target, and protecting their professional reputation—while also attempting to provide patient care that aligned with their professional obligations.

Conclusion

In this chapter, I provided a brief summary of the theory, and positioned the findings into the current literature. Key findings from this study included contributions to clarifying the definition of moral distress through an examination of moral agency at the intersection of structure and agency. Early in the analysis it became clear that all participants enacted moral agency to various degrees and that constraints on agency were dependent on the immediate context of the participant. This finding highlights the dynamic nature of moral agency as participants responded to structural elements that influenced decision-making

about what options for taking action were open to the participant in that specific context. This view of moral agency is supported by Milliken (2018), who draws on insights from the fields of moral philosophy and moral psychology to refine our understanding of moral agency. I also explored the role of constraints in the experience of moral distress in the context of the current literature on moral distress in two ways. First, in line with current critiques of the definition of moral distress (Fourie, 2015; Morley et al., 2017), I wonder if constraints on moral agency is a necessary condition of moral distress. Second, I draw on Peter and Liaschenko's (2013) examination of moral distress through a feminist lens. Using a feminist perspective, Peter and Liaschenko's (2013) highlight the socially constructed nature of our moral identity. Specifically, these authors focus on the social construction of the moral identity, relationships, and responsibilities of the nurse. Ultimately, Peter and Liaschenko (2013) argue that moral distress results from constraints on moral identity, relationships, and responsibilities.

Another key finding in this study was the problem that participants were attempting to navigate as they enacted moral agency: *systemic inhumanity*. *Systemic inhumanity* was the inability of people in the health care system to consistently extend respect, dignity, and compassion to people struggling with mental health issues. I argued that *systemic inhumanity* was underpinned by an idealized (Ho, 2008), and unrealistic, view of autonomy, along with discourses of efficiency and scarcity. I then provided examples for this study about how the discourses of efficiency and scarcity were built into policies and practices that served to obscure the ethical consequences of these policies and practices. I

also described the practice of *offloading responsibility* that occurred at all levels of the health care system. As well, I discussed *safety and high-stakes situations*. I presented both of these key findings primarily through the examples from two specific population groups that featured prominently in participants' narratives, the forensic population with concurrent mental health diagnosis, and the dual diagnosis patient population. In the case of the forensic population, particularly patients with a diagnosis of APD and who directed acts of aggression toward others to get their needs met, there was the sense that these patients were unworthy of care. Safety and high-stakes situations encompassed both the increasing risk of aggression directed at patients and staff, and the risk for exploitation that confronted some of the DD patients.

I also discussed the significant role organizational and program leadership played in shaping the context in which participants worked, thereby influencing the options for taking action. One way in which leadership had the capacity to shape the immediate environment of the participant was in the way leadership responded to situations of bullying. In most cases, participants relayed that the organization had policies in place to address bullying. However, they experienced these policies as meaningless, because organizational leadership did not address the behaviour effectively. In fact, several participants relayed that bullying was not only tolerated, individuals who engaged in bullying behaviour were promoted within the organization. On units where bullying behaviour was not dealt with effectively, participants expressed having fewer options for taking action available to them to address bullying. Instead, these participants directed

their actions toward protecting themselves and attempting to mitigate bullying behaviour toward patients. In these situations, participants expressed a lack of trust in the leadership that, at times, extended to a lack of trust in the organization in general. This finding supports research by Vickers (2012) in which the author examines the ways employees can feel betrayed by the appearance of organizational support for bullying, only to have their concerns minimized or dismissed.

Organizational leadership also had the capacity to influence moral agency in a positive way. Some participants clearly described how their manager supported them by intentionally connecting with them through regular meetings, either individually or in team meetings. These participants described their manager as trustworthy. They also described having a collaborative team with whom they could discuss ethical challenges. Participants, who experienced their manager as supportive, also described feeling empowered to take action with the support of their team. This finding lends support to research by Udod (2012) who conducted research on nurse empowerment. While Udod's (2012) work focused on social connectivity with the manager as a means for nurses to provide high-quality care, and this study was focused on navigating ethical challenges, there were shared outcomes. Similar to Udod's (2012) study, when HCPs experienced their manager as collaborative, willing to share information and resources, HCPs experienced greater autonomy and capacity for enacting moral agency.

These key findings have implications for developing theoretical clarity in the definition of MD, along with implications for mental health care policy,

education, particularly nursing education, practice, and research. I will discuss the implications for each of these areas in Chapter Seven.

Chapter 7 Implications and Opportunities for Further Inquiry and Action

In this dissertation research, my discovery that the basic social problem participants were attempting to navigate was *systemic inhumanity* was, to me, a surprising finding. Based on my own past mental health practice and my review of related research and other literature, I was prepared to hear about the difficulties related to lack of human and physical resources to adequately treat patients struggling with mental health and substance use problems. However, I was not prepared for the accounts of the pervasive lack of respect, dignity, and compassion that participants described as resulting from policies and practices that defined and circumscribed care delivery in acute mental health care. The elements that I have articulated as contributing to systemic inhumanity are, I believe, complex, intertwined, and not well understood. I say this because people in the provincial government and health authorities publish reports, frameworks, and policies intended to improve mental health services in the province,⁵⁸ and Health Authorities have been diligent in building spaces into their EDs specifically designed to attend to patients with mental health issues. The standards for mental health care that HCPs are taught to uphold, and that are reflected in their respective Codes of Ethics, are also well defined. However, despite these efforts,

⁵⁸ For examples of government and Health Authority efforts please see BC Mental Health & Addiction Services (2011), *The Provincial Suicide Clinical Framework*; BC Provincial Mental Health and Substance Use Planning Council (2013) *Trauma Informed Practice Guide*; and Ministry of Health (2012), *Secure rooms and seclusion standards and guideline: A literature and evidence review*.

people working in the health care system struggle collectively to respond with respect, dignity, and compassion to people struggling with mental health issues.

One of the obvious contributors to *systemic inhumanity* that I highlighted in Chapter Six (the discussion chapter) included policies such as Pay-for-Performance,⁵⁹ based on CTAS scores that may not adequately reflect the needs of patients presenting with mental health issues (Brown, Clarke & Spence, 2015). A second contributor was the lack of treatment or housing resources for increasingly complex mental health population groups, specifically the forensic population, and people with an ID. A further contributor to *systemic inhumanity* was the ways in which the discourses of scarcity and efficiency supersede the values of health care as primary drivers in discussions on health care decision-making. Findings from my dissertation have implications for addressing *systemic inhumanity* and support the ethical practice and moral agency of HCPs and, ultimately, to enhance the quality of health care provided to mental health population groups.

Theoretical Implications

The findings from this research support and add to the current literature on developing conceptual clarity on the definition of moral distress. A critical examination of the definition using different theoretical lenses, and from

⁵⁹ As noted in Chapter Six, this provincial initiative by the Ministry of Health was designed as a financial incentive project in an attempt to decrease patients' length of stay in the ED. Readers are referred to Cheng and Sutherland (2013) for a review of the effectiveness of the pilot.

disciplinary perspectives outside of nursing, has had a meaningful impact on moving the discussion forward in diverse scholarly arenas. Specifically, scholars examining the necessary and sufficient conditions for the experience of moral distress open the door to understanding the experience as non-linear and not dependent on the specific cause of constraints (Morley, Ives, Bradbury-Jones & Irvine, 2017; Fourie, 2015; Musto & Rodney, 2015). Several participants in this study provided examples of having taken action despite constraints on their moral agency. However, they did not endorse the conclusion that taking action alleviated or ameliorated their moral distress. Instead, several participants acknowledged that they “experienced moral distress all the time,” and that taking action made it liveable for the moment.

The actions taken by participants occurred at the nexus of structure and agency, and were influenced by dynamic elements, such as political, organizational, social, and interpersonal aspects of the context. Continued interrogation of the concepts that underpin moral distress from other theoretical perspectives, such as philosophy, moral psychology, and neuroscience, is needed to achieve an incisive understanding of the experience. With a clearer understanding of MD, we can follow-up with interventions that support HCP moral agency that interjects humanity into the policies and processes of care provision, thereby humanizing people who struggle with mental health issues, have an ID, or a history of criminal behaviour.

Drawing on Theoretical Concepts from Across Disciplines

Rushton et al. (2013b) offer an example of developing a framework for understanding moral distress by integrating research on empathy, compassion, and empathetic distress from the disciplines of neuroscience and social psychology. The framework provides opportunities to understand the different moral responses to the suffering of others, e.g. MD, as a dynamic process with multiple points to intervene (Rushton, Kaszniak & Halifax, 2013b). The researchers draw on neuroscience and social psychology to explain the emotional dysregulation (distress), and responses that occur when empathy or compassion are aroused by witnessing suffering. The suggested interventions are designed to regulate emotional states so that HCPs can respond intentionally to enact moral agency to uphold moral principles, values, or standards. Rushton et al. (2013b) also claim that if arousal is regulated then the “aroused state can give rise to compassion, with the manifestation of other focused behaviors such as altruism and principled compassionate action” (p. 3). Principled compassionate action helps preserve the HCP, as well as humanize the patient needing care. This example drawn from the literature demonstrates how interrogating MD from other theoretical perspectives can deepen our understanding of the experience.

The multidisciplinary nature of this study also supports our understanding that moral distress is not confined to the discipline of nursing, and some participants from across the disciplines endorsed experiencing moral distress. In this study for example, social workers, occupational therapists, and psychiatrists

acknowledged experiencing MD in response to ethically challenging situations. There were also similarities in the causes of moral distress across disciplines, such as barriers to humane care caused by a general lack of treatment and housing resources to refer patients to, as well as the siloed nature of trying to work across sectors. For example, one psychiatrist described the frustration of having to fill out paper work for patients in order to request housing instead of being able to directly call the person responsible for services. The psychiatrist pointed out that the forms were not able to capture the complexity of some patients' needs and it would speed up the process if they could speak directly to someone. Another theme that I heard from participants across disciplines was that moral distress occurred when participants perceived that the incident violated their professional obligations, such as, spending time with patients to attend to their emotional needs (nurses), or attempting to fulfill competing obligations such as respecting patient autonomy and protection of the public (psychiatrist; (Austin et al., 2003; Austin et al., 2008).

This theme supports more recent theoretical writing by Peter and Liaschenko (2013) on moral agency from a feminist perspective. Peter and Liaschenko (2013) offer a rich understanding of what is morally at stake in the experience of moral distress. They identify three core elements of moral agency as identity, relationships, and responsibilities, asserting that “[t]hese elements rest on a conception of moral agency as socially connected, implying that people’s ability to identify, deliberate, and act on moral phenomena occurs in a relational context” (p. 338). Although Peter and Liaschenko’s work is focused on

nursing, the participants' narratives in my study, and the actions they took to address the situations they described, regardless of disciplinary perspective, mirrored Peter and Liaschenko's description.

In addition, Milliken (2018) draws on theories from moral philosophy and moral psychology in order to provide a rich and nuanced understanding of moral agency. Research in moral psychology highlights the profound influence the environment has on moral decision-making, to the extent that minute changes in the environment can alter moral judgment (Milliken, 2018). This being the case, Milliken (2018) suggests that "moral agency must be conceptualized in a way that reflects the fluid, ever-changing dynamics of health care settings and the way these dynamics can influence decision-making and the mind" (p. 4). This view of moral agency can help provide an explanation for the relational and contextualized influences on agency that emerged in this study. Participants regularly spoke about several situations that reflected the enactment of moral agency. In these situations, participants described their moral agency as being more or less constrained by contextual features, for example, who was present in that moment, how much support they received from leadership, and the busyness of the shift. Thus, we need to build on this work, work that offers possible explanations of the processes that underpin and contribute to our understanding of the complexity of decision-making and moral agency. Milliken suggests that interventions to improve moral agency and decrease moral distress should be targeted at the systems level. I push this suggestion further, adding that interventions need to be multipronged and directed at both the agent (HCP), and

the systems level.

Power and Moral Agency

Participants from across disciplines used language that conveyed the belief that they thought they did not have power or authority to change systemic issues. Nurses and social workers spoke about physicians having the power to admit and discharge patients, or having to certify a patient under the MHA, while physicians referred to administrators having power over resources. In other words, many HCPs, regardless of their position or professional affiliation, felt powerless in the health care system. In fact, many participants seemed to believe uncritically that power to create change resided in the person immediately above them in authority. At times, this belief contributed to *offloading responsibility*, by pushing responsibility to act upwards in the organization. Other participants revealed a strong sense of personal power, and talked about trying to intervene at a local level to create change. In specific situations, these participants forged alliances with those they believed had some power in the health care system, talking to mentors or colleagues who had been in the organization longer and had awareness of organizational processes, or seeking guidance, or direction from their direct leadership.

Practice Implications

Tipping in and out of Moral Distress: Influences

Several participants recounted experiencing moral distress as they navigated ethical challenges. However, they also described not being left in a

state of distress because they worked in a supportive environment within a team that created space for the discussion of ethical issues. At times, this was the clinical team and these discussions occurred in multidisciplinary team rounds. At other times, participants described going to a specific disciplinary team for clinical supervision, or being part of a leadership team that met regularly to discuss program issues. The commonalities were that the team created a space that was safe; participants felt they could raise ethical issues that would be taken seriously, and they felt respected within the team. They also expected that the team would be supportive and offer helpful suggestions or organizational resources, such as Human Resources or the Ethics Consultation Team.

Participants who reported working on teams that were open to discussion of ethical concerns, also described the experience as strengthening the team and attributed good intentions to the organization. Further, these participants described having a boss who maintained regular meeting times regardless of what was on the agenda. For example, one participant in a leadership position stated that at times, the meetings with little on the agenda opened up the most productive discussions of how the team was doing, providing opportunity to address ethical issues raised by the staff. In contrast, participants who described working on teams that did not have regular meetings, or the meetings were cancelled if the supervisor didn't believe the items on the agenda were urgent or relevant, also described having limited support from their peers or manager to address ethical issues. They were also likely to admit having ethical issues, such as bullying, dismissed by their manager or leadership as an "interpersonal issue."

These participants described their leadership as personally supportive but ineffective at addressing ethical issues.

Leadership and the Creation of Space for Ethical Discussions

Moral agency as a relational activity meant being able to discuss ethical challenges with those who had some amount of organizational authority to intervene in the situation (Rodney, Buckley, et al., 2013; Rodney, Kadyschuk, et al., 2013). Several participants bemoaned that they sent information via established organizational channels, such as electronic notes or referrals, but were never certain about the ultimate destination of the information. They believed that direct conversations about the issues held greater possibility for navigating challenges. These findings have implications for health care organizations, leadership, and teams. If, as participants in this study indicated, being a moral agent is a relational activity, then health care organizations have a responsibility to create time and space that foster relational activities (Regan, Laschinger & Wong, 2016). In some situations, these activities could include team meetings or the re-establishment of unit rounds that are attended by staff providing direct care, instead of the information being passed on by someone in a leadership position. Fostering relational activities may include having DC staff who hold important information about complex patients, such as those with a dual diagnosis, being permitted to attend higher level meetings to participate in decision-making and allowing for the development of cross-sector relationship-building. These suggestions illustrate the important position of leadership in cultivating a safe environment to raise ethical concerns.

Leadership has been noted to play an integral role in inter-professional practice, effective team functioning, and mitigating the impact of stressful health care environments on staff (Bowers, Nijman, Simpson & Jones, 2011; Gabel, 2012; Hanrahan, Aiken, McClaine & Hanlon, 2010; Tang, Chang, Zhou & Liaw, 2013; Udod, 2012). Given the significant constraints on moral agency described in this study by staff experiencing bullying from colleagues, organizations need to find ways to genuinely support middle management intercede in meaningful ways when staff bring these situations forward. This may be by reducing the workload of managers so they can be present in the programs or unit they are responsible for. Other strategies may involve education and coaching middle managers in how to supervise personnel. Further, organizations could offer extended training in managing situations with staff that engage in bullying behaviours.

In my research, I noted a significant disconnect in the opportunity to participate in ethical discussion between participants who worked in direct care and participants who had stepped into leadership roles. Most participants who worked in providing direct care described having only their immediate team as support. If the team was not supportive, participants admitted having limited opportunity, or no avenue to address ethical issues. I also noted that participants who described working in a difficult team did not always recognize bullying as an ethical issue.

Direct care staff had limited opportunity to participate in regular meetings and had little contact with supervisors or managers. Several participants working in direct care delivery acknowledged that participating in this study and talking

about ethical practice had been helpful and suggested these kinds of discussions needed to take place on the floor. Diverse researchers in moral distress have recognized the necessity of creating access for direct care staff to discuss ethical issues in a safe environment (Rushton, Kaszniak, & Halifax, 2013b; Rushton, Caldwell & Kurtz, 2016; Musto, Rodney & Vanderheide, 2015). For example, as pilot studies, several researchers have trialed facilitated ethics conversations for bedside nurses on hospital units to improve access for direct care staff (Helft, Bledsoe, Hancock, & Wocial, 2009; Wocial et al., 2017). Although these studies have been conducted in medical areas, it may be helpful to initiate a pilot study having facilitated ethical conversations in acute care mental health units to foster increased awareness of ethical issues, provide safe space to discuss concerns, and offer suggestions for how to navigate ethical challenges. I discuss this further in the section on research implications.

Clinical Supervision

It is also worth noting that participants who were physicians, social workers, and occupational therapists had discipline-specific meetings away from the units they worked on, where they stated that they could go for clinical supervision and support when they confronted ethical issues. Participants, who had this option, acknowledged that they found it helpful to talk to colleagues who shared their disciplinary perspective as they navigated ethical challenges. Nursing was the only discipline that had no organizationally sanctioned, discipline-specific meetings that HCPs could take ethical concerns to. Thus, all of

the participants who expressed they felt isolated and had no one with whom they could share their concerns were also nurses.

Clinical supervision for ongoing practice development in nursing, while common practice in the United Kingdom and Europe, is not generally practiced in Canada.⁶⁰ Researchers have shown that clinical supervision may have a positive impact on the development of professional identity, professional accountability, improved ethical decision-making, positive patient outcomes, and also serve to buffer against burnout (Brunero & Stein-Parbury, 2008; Severinsson & Sand, 2010; Wallbank, 2010). To support ethical practice and moral agency in nursing, and decrease burnout, it may be helpful to establish a pilot project whereby clinical supervision is offered to nurses working in mental health programs. This intervention would cultivate discussion and reflection about ethical practice from a discipline-specific perspective. As well, clinical supervision would provide nurses with an organizationally sanctioned avenue for discussion of ethical challenges.

Implications for Education

Researchers studying moral distress have started to expand the exploration of the experience for students in health care disciplines (Krautscheid et al., 2017; Wiggleton et al., 2010). In part, they are doing so to determine if

⁶⁰ I am aware of nurses in some community mental health settings participating in interdisciplinary group clinical supervision that focuses on practice issues. A psychologist often led the sessions. The nurses who participate in clinical supervision recognize that it has been helpful.

moral distress is an issue for students in healthcare disciplines, and if so, to what extent. In addition, researchers have indicated that they want to consider interventions during the educational process that will help inoculate new graduates against experiences that contribute to the demoralization and attrition of new graduates from health care. These include such experiences as moral distress, moral disengagement, burnout, and compassion fatigue (Gabel, 2012; Monrouxe, Rees, Dennis & Wells, 2015). For example, Monteverde (2014) tested an educational intervention on nursing students that was directed at helping students shift their focus away from being overwhelmed by moral stress and experiencing moral distress, and toward fostering moral resilience. In this process, students learn to distinguish between *morally complex* and *morally wrong* situations, as well as how to transform a *morally opaque* situation to a *morally transparent* situation. The purpose is to develop moral resilience and allow students to provide a moral response when one is required, as well as to inoculate them against burnout that can occur when students must navigate situations of moral uncertainty without compromising themselves. This kind of educational intervention supports students in developing an ethical language to discuss the ethical challenges they will experience working in health care. It may also help nurses recognize the boundaries of their professional responsibilities in complex organizations and help them determine avenues for advocacy on behalf of the patient.

On the basis of my analyses in this research study, it was clear that having a sanctioned space, such as patient rounds or team meetings, to talk

about ethical issues was central to navigating ethical challenges. Both inter-professional and discipline-specific discussions were also important for teasing out the ethical issues and discerning professional boundaries of obligations and actions. Taking up professional identity, which begins with the educational process (Ranjbar, Joolaee, Vedadhir, Abbaszadeh & Bernstein, 2016), and then learning how to speak about moral stressors from a disciplinary perspective, may be the important steps in fostering moral agency in HCPs. Toward this end, academic settings need to be intentional about providing the language of values and ethics so that students can articulate ethical issues. The next step is inter-professional ethics education that provides opportunity for students to develop the language of ethics further in an interdisciplinary context. Inter-professional ethics education could occur through the collaborative development of a health care ethics course, across health disciplines. Also, Strawbridge, Barrett and Barlow (2014) used inter-professional education and debating as a pedagogical tool to encourage students to consider alternate viewpoints on ethical issues. As part of the curriculum, they established twelve debate teams and assigned each team an ethical issue to debate. Eight of the teams were inter-professional, made up of an equal number of pharmacy and physiotherapy students. Although the study was small, students acknowledged the benefits of having to work as part of an interdisciplinary team (Strawbridge, Barrett, & Barlow, 2014).

Policy Implications

In discussing *policy*, I am directing suggestions at broader government and professional agencies responsible for providing direction for health care and health care delivery. I draw on Villeneuve's (2017) recent work on public health policy and understand policy as referring to a framework developed to address identified population issues. The framework incorporates ideas and values directed at addressing these issues (Villeneuve, 2017). There were several aspects of this research that were ethically and psychologically disturbing; foremost was recognizing the depth of *systemic inhumanity* directed at mental health patients. Systemic inhumanity at the point of care delivery is a reflection of the *is/ ought gap* that begins at the level of the provincial Ministry of Health, and is reflected in subsequent policies. Mental health policies from all levels of government call for a collaborative cross-sector approach to addressing the factors that contribute to significant mental health struggles (BC MoH, 2017).

Across this research, participants provided examples of how cross-sector collaboration was a sham. My analysis indicated that cross-sector collaboration appeared to be a euphemism for shifting responsibility for care onto another sector. This was particularly evident when participants spoke about trying to arrange housing and supports for complex patients with a diagnosis of ID. Ultimately, people struggling with mental health issues were moved around the system (e.g. patients with a forensic history may be admitted to the acute care unit for brief periods, then discharged without appropriate housing, only to return to the ED), or physicians used the MHA to detain people in an acute care setting

until housing and services could finally be arranged in the community⁶¹. In several cases, this took several months, and sometimes even more than a year.

Participants identified two population groups that were at particular risk: the forensic population and people with an ID.⁶²

Addressing mental health issues is an intricate business because of the social determinants that contribute to a person's well-being. However, people with a forensic history or an ID have an added layer of complexity. The discourse of efficiency that underpins decision-making in health care requires the development of policies and mandates that are narrow, and in effect, that exclude people with complex needs from receiving services. Participants' accounts of how complex patients, who came to the hospital for treatment, were deflected out of care, refused admission, or discharged, and escorted off the grounds, were to a certain degree, confirmed by stories in the media.⁶³

Suggestions for policy begin with the Ministry of Health and the new Ministry of Mental Health and Addictions. In an attempt to bridge the *is/ ought*

⁶¹ At the time of writing Chapter Six, the discussion chapter, the Community Legal Assistance Society released a report on BC MHA, entitled *Operating in Darkness* (Johnston, 2017). Some of the findings in the report mirror comments from my participants. Several participants commented on the ability of psychiatrists to use the MHA "flexibly," or that BC had the most lenient MHA in Canada.

⁶² Dual diagnosis refers to individuals with a developmental delay and a mental health diagnosis (Byrne, Hurley, & James, 2007), and the forensic population refers to people who have a mental health diagnosis and a history with the criminal justice system

⁶³ For details, please visit: <http://www.cbc.ca/1.3963806> or <http://vancouversun.com/health/local-health/what-to-do-about-kyle-health-care-system-has-no-place-for-paralyzed-mentally-ill-and-drug-addicted-man>

gap, or bring together the values of health care with the identified strategies for achieving these values, there needs to be transparent and intentional public dialogue about how values and strategies work together. Deliberative democracy is a process recognized as a useful tool to facilitate public engagement in policy (Burgess, 2014; McWhirter et al. 2014). Although there are different ways to go about organizing a deliberative process, at its core it is the intention to bring together diverse members of the public to have a policy discussion that will inform public policy (O'Doherty & Davidson, 2010). Deliberative democracy processes, if done well, can help policy makers and practice leaders consider trade-offs between moral values and practical constraints (Burgess, 2014). On the basis of this research, I would encourage the provincial Ministry of Health and the Ministry of Mental Health and Addiction engage genuinely in deliberative democracy processes as they develop and implement policy on mental health care delivery.

Throughout this study, one of the personal questions that informed my analysis was, "If this space were used by another program, such as the cardiac program, would cardiac patients be treated in the same way as mental health patients?" I believe that, in general, the answer is "no." Cardiac patients are generally considered worthy of care and would not have to eat food off the floor. They would not be overcrowded and moved from a bed to a chair to a SR because more patients were being moved in. In most cases, cardiac patients would not be discharged or deflected from the hospital because they were undesirable or considered undeserving of care.

Health authorities need to review their policies to see if policies that are intended to improve the quality of health care for patients with physical medical needs have a negative impact on mental health patients. Examples of this are the Pay-for-Performance incentives that were introduced by the provincial government in an effort to decrease wait times in the EDs. The results from that pilot project were mixed, and some hospital EDs were able to decrease wait times while other hospitals were not (Cheng & Sutherland, 2013). It is also not clear how this incentive influenced care of mental health patients, although participants in this study attributed negative consequences in patient care to the introduction of this policy. Examples of negative consequences included the lack of a clearly enforced cap on the number of patients in the psychiatric area, even in circumstances of significant overcrowding. Participants also spoke of conducting short or non-existent intake assessment on mental health patients in order to move them through the department more quickly.

Research Implications

The findings of this study, along with the theoretical implications identified above, point to several areas for further research. I was able to explore how HCPs interacted with contextual elements, such as organizational policy, and healthcare teams, to enact moral agency. Moral agency is enacted relationally, and participants benefitted from working with supportive teams who were open to discussing ethical issues. Participants were also able to identify some of the things they believed contributed to being able to raise ethical issues, for example

having regular team meetings. Participants also described the benefits of engaging in ethical discussions with the team. However, I was not able to ascertain the qualities of the team that allowed participants to raise ethical concerns in the first place. By this, I mean I did not explore the power dynamics within teams that fostered or constrained the raising of ethical issues. Further research is needed to understand the processes of ethical decision-making within health care teams.

In addition, the participants who volunteered for this study clearly demonstrated awareness of ethical issues in their practice and discussed their moral obligations in the context of their professional values. They also spoke about talking to peers or mentors about ethical situations. At the same time, many of the stories I heard involved HCPs in central roles behaving unethically. Being exposed to these contradictory behaviours highlighted the fact that we do not understand why some HCPs maintain their ethical compass and why other HCPs in a similar, or the same, environment lose their moral compass. Further research, specific to mental health settings, is needed to examine elements that contribute to ethical comportment. This would shed light on how organizations, educational institutions, and professional bodies can support ethical development in HCPs

Limitations of This Study

In conducting this grounded theory research, I developed a theory that was contextually relevant to the locations where I studied. Thus, a limitation of

this study is that it is bound by the time and space in which it occurred. Another of the limitations of this study is that I was not able to interview anyone from above the manager level of leadership. This meant that I could only discuss participants' *perceptions* of senior management. As I noted earlier, participants made assumptions about the power and authority vested in the position immediately above them. These assumptions may have contributed to negative perceptions participants expressed about senior leadership, such as the impression that they did not care about bullying in the organization. It would also have been helpful to speak to someone in senior leadership to explore their perceptions of power at different levels of the organizational structure, including relationships at provincial and national levels. Understanding perceptions of power within the organizational structure may help explain some of the elements that contributed to *offloading responsibility for care*

Another limitation of my research findings is that few participants consented to allowing me to observe them in their work. The participants who did agree were all nurses, albeit from across areas involved in the study. The first reason participants gave for being uncomfortable with being observed related to patient confidentiality; participants expressed concerns that my presence would infringe on the patient's right to confidentiality. The second reason was that they perceived themselves as not doing anything except talking on the phone, going to meetings, or filling out paperwork; therefore, they did not believe I would glean anything from observing them. Given what I know now, if I were conducting this

study again, I would arrange to spend time doing general observation of the area and not attach observation to a particular participant.

A third limitation of this was that it was confined to acute care mental health settings. Although there may be shared issues across acute and community mental health care that are perceived as ethically challenging, there are likely ethical challenges that are unique to the community setting. Because this study was focused on acute mental health care, I did not get to explore constraints on intersectoral collaboration from alternate perspectives such as forensics or the community mental health teams. If I were to repeat this study, I would extend the study to include both community and acute mental health care settings. As well, I would try to include participants from other sectors.

Conclusion

Going back to the beginning of this dissertation, my desire to support the ethical practice of HCPs grew out of clinical practice situations that served as a personal call to action. My journey as both a clinician and graduate student moved me beyond the individual experience of MD to understanding that MD was only one of the possible consequences that resulted from confronting ethical challenges.

I began this research endeavour with the intention of exploring how HCPs in mental health navigate morally charged situations and enact their moral agency within their health care organizations. I learned that the primary problem participants were attempting to negotiate was *systemic inhumanity*, and that all

participants took action when confronted with ethical challenges, although only a few participants took “big actions.” This indicates that most participants hold onto and exercise some level of personal power in their work environment. However, their own sense of personal power is deeply influenced by the specific situation, the culture of the immediate team they are in, along with their past experiences of exercising moral agency in the team or organization, and the level of support they experienced from professional practice mentors. The contextual features are dynamic, thus what a participant will do in a given situation is not entirely predictable.

Having said this, participants consistently described elements that supported the enactment of moral agency, including sanctioned time and space where ethical issues could be brought up and discussed. Participants also identified having a leader or team that supported and empowered, often on an ongoing basis, as helpful. Research in leadership and health care environments indicates that directing interventions at the level requiring change would be an effective place to intervene. However, to create sustained change, targeting interventions at every level of the organization may be most effective (Bowers, Nijman, Simpson & Jones, 2011). To effect deeper change targeted at *systemic inhumanity*, interventions directed only at individuals will not be effective. In addition, interventions directed at bridging the *is/ ought gap*, by having explicit and transparent discussions about how societal values are worked out with practical constraints (such as cost) need to occur with government actors as role models for such discussion.

References

- Agger, B. (1998). *Critical social Theories: An Introduction*. Boulder, CO: Westview Press.
- Alverson, M., & Skoldberg, K. (2009). (Post-)Positivism, social constructionism, critical realism: Three reference points in the philosophy of science *Reflexive Methodology: New Vistas for Qualitative Research* (2nd ed.). Los Angeles, CA: SAGE.
- American Association of Critical-Care Nurses. (2008). Moral distress public policy position statement. Aliso Viejo, CA: Authors.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- American Psychiatric Nurses Association. (2012). APNA position statement: Staffing inpatient psychiatric units. *Journal of the American Psychiatric Nurses Association*, 18(1), 7.
- Anderson, J. M. (1991). Reflexivity in fieldwork: Toward a feminist epistemology. *Journal of Nursing Scholarship*, 23(2), 115-118. doi: 10.1111/j.1547-5069.1991.tb00654.x
- Angus, J. E., & Clark, A. M. (2012). Using critical realism in nursing and health research: Promise and challenges. *Nursing Inquiry*, 19(1), 1-3. doi: 10.1111/j.1440-1800.2011.00580.x

- Archer, M. S. (2007). Realism and the problem of agency. *Journal of Critical Realism*, 5(1), 11-20. doi: 10.1558/aleth.v5i1.11
- Arras, J. (2010). Theory and bioethics. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Summer 2013 ed.). Retrieved from <http://plato.stanford.edu/archives/sum2013/entries/theory-bioethics/>.
- Austin, C. L., Saylor, R., & Finley, P. J. (2016). Moral distress in physicians and nurses: Impact on professional quality of life and turnover. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(4), 399-406. doi: 10.1037/tra0000201
- Austin, W. (2011). The incommensurability of nursing as a practice and the customer service model: An evolutionary threat to the discipline. *Nursing Philosophy*, 12(3), 158-166. doi: 10.1111/j.1466-769X.2011.00492.x
- Austin, W. (2012). Moral distress and the contemporary plight of health professionals. *HEC Forum*, 24(1), 27-38. doi: 10.1007/s10730-012-9179-8
- Austin, W. (2016). Contemporary healthcare practice and the risk of moral distress. *Healthcare Management Forum*, 29(3), 131-133. doi: 10.1177/0840470416637835
- Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experience of moral distress. *Nursing Inquiry*, 10(3), 177-183. doi: 10.1046/j.1440-1800.2003.00181.x
- Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as

experienced by psychologists. *Ethics & behavior*, 15(3), 197-212. doi:
10.1207/s15327019eb1503_1

Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2008). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Healthcare, and Philosophy*, 11(1), 89-97. doi: 10.1007/s11019-007-9083-1

Bandura, A. (2002). Selective moral disengagement in the exercise of moral agency. *Journal of moral education*, 31(2), 101-119.

Bell, J., & Breslin, J. M. (2008). Healthcare provider moral distress as a leadership challenge. *JONA'S Healthcare Law, Ethics and Regulation*, 10(4), 94-97. doi: 10.1097/NHL.0b013e31818ede46

Benner, P. (2000). The roles of embodiment, emotion and lifeworld for rationality and agency in nursing practice. *Nursing Philosophy*, 1(1), 5-19.

Bergen, M., Wells, J. S. G., & Owen, S. (2008). Critical realism: A philosophical framework for the study of gender and mental health. *Nursing Philosophy*, 9, 10.

Bergum, V. (2013). Relational ethics for health care. In J. L. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 127-142). Toronto, ONT: Pearson.

Bergum, V., & Dossetor, J. (2005). *Relational ethics: The full meaning of respect*. Hagerstown, MD: University Publishing Group.

Beumer, C. M. (2008). Innovative solutions: the effect of a workshop on reducing the experience of moral distress in an intensive care unit setting.

Dimensions of Critical Care Nursing, 27(6), 263-267. doi:
10.1097/01.DCC.0000338871.77658.03

Bhaskar, R. (1975). *A realist theory of science*. London, UK: Verso.

Blackburn, S. (Ed.) (2016) *Oxford Dictionary of Philosophy* (3rd ed.). New York, NY: Oxford University Press.

Blom, B., & Morén, S. (2011). Analysis of generative mechanisms. *Journal of Critical Realism*, 10(1), 60-79. doi: 10.1558/jcr.v10i1.60

Bluhm, R. (2014). No need for alarm: A critical analysis of Greene's dual-process theory of moral decision-making. *Neuroethics*, 7(3), 299-316. doi:
10.1007/s12152-014-9209-0

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkely, CA: University of California Press.

Bonner, A., & Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher*, 9(4), 7-19.

Borry, P., Schotsmans, P., & Dierickx, K. (2005). The birth of the empirical turn in bioethics. *Bioethics*, 19(1), 49-71.

Browne, A. J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry*, 8(2), 118-129. doi: 10.1046/j.1440-1800.2001.00095.x

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: an evidence based literature review. *Australian Journal of Advanced Nursing*, 25(3), 86-94.

- Bryant, A., & Charmaz, K. (2007a). Grounded theory in historical perspective: An epistemological account. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of Grounded Theory* (pp. 31-57). London, UK: SAGE Publishing.
- Bryant, A., & Charmaz, K. (2007b). Grounded theory research: Methods and practices. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 1-28). London, UK: SAGE Publications.
- Burston, A. S., & Tuckett, A. G. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. *Nursing Ethics*, 20(3), 312-324. doi: 10.1177/0969733012462049
- Canadian Institute for Health Information. (2011). Health care cost drivers: The facts. Ottawa, Ont: CIHI.
- Canadian Institutes of Health Research. (2015). *Guide to knowledge translation planning at CIHR: Integrated and end-of-grant approaches*. (MR4-11/2012E-PDF). Ottawa, Ont: Author Retrieved from <http://www.cihr-irsc.gc.ca/e/45321.html>
- Canadian Nurses Association. (2012). Staff mix decision-making framework for quality nursing care. Ottawa, On.
- Carpenter, C. (2010). Moral distress in physical therapy practice. *Physiotherapy Theory and Practice*, 26(2), 69-78. doi: 10.3109/09593980903387878
- Carse, A. (2013). Moral distress and moral disempowerment. *Narrative Inquiry in Bioethics*, 3(2), 147-151. doi: 10.1353/nib.2013.0028

- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: SAGE.
- Charmaz, K. (2011). Grounded theory methods in social justice research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (4 ed., pp. 359-380). Thousand Oaks: CA: SAGE Publications.
- Chenitz, W. C., & Swanson, J. M. (1986). *From practice to grounded research*. Menlo Park, CA: Addison-Wesley Publishing Company.
- Clark, A. M., Lissel, S. L., & Davis, C. (2008). Complex critical realism: Tenets and application in nursing research. *Advances in Nursing Science*, 31(4), E67-E79.
- Clarke, S., & Aiken, L. H. (2003). Failure to rescue. *The American Journal of Nursing*, 103(1), 42-47.
- Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636-650. doi: 10.1191/0969733002ne557oa
- Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, 12(4), 381-390.
- Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing*, 26, 623-630.
- Crane, M. F., Bayl-Smith, P., & Cartmill, J. (2013). A recommendation for expanding the definition of moral distress experienced in the workplace. *Australian and New Zealand Journal of Organisational Psychology*, 6. doi: 10.1017/orp.2013.1

- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW: SAGE Publications.
- Cruickshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: a philosophical orientation. *Nursing Inquiry*, 19(1), 71-82. doi: 10.1111/j.1440-1800.2011.00558.x
- Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P., & Lees, D. (2015). Raiders of the lost art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24(5), 375-385. doi: 10.1111/inm.12159
- D'Andreamatteo, A., Ianni, L., Lega, F., & Sargiacomo, M. (2015). Lean in healthcare: A comprehensive review. *Health Policy*, 119(9), 1197. doi: 10.1016/j.healthpol.2015.02.002
- Damasio, A. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York, NY: Penguin Books.
- Damasio, A. (1999). *The Feeling of What Happens*. New York, NY: Houghton Mifflin Harcourt Publishing Company.
- Damasio, A. (2007). Neuroscience and ethics: Intersections. *The American Journal of Bioethics*, 7(1), 37-41. doi: <http://dx.doi.org/10.1080/15265160601063910>
- Damasio, A. (2010). *Self comes to mind*. New York, NY: Pantheon Books.
- Danermark, B. (2002). Interdisciplinary research and critical realism: The example of disability research. *Journal of Critical Realism*, 5(1), 56-64.

- Davidson, R. J., & McEwen, B. S. (2012). Social influences on neuroplasticity: stress and interventions to promote well-being. *Nature neuroscience*, 15(5), 689-695. doi: 10.1038/nn.3093
- De Villers, M. J., & DeVon, H. A. (2012). Moral distress and avoidance behavior in nurses working in critical care and noncritical care units. *Nursing Ethics*, 20(5), 589-603. doi: 10.1177/0969733012452882
- Deady, R. (2012). Studying multidisciplinary teams in the Irish Republic: The conceptual wrangle. *Perspectives in Psychiatric Care*, 48(3), 176-182. doi: 10.1111/j.1744-6163.2011.00326.x
- Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in psychiatric care*, 46(3), 209-220. doi: 10.1111/j.1744-6163.2010.00260.x
- Decety, J., Michalska, K. J., & Kinzler, K. D. (2011). The developmental neuroscience of moral sensitivity. *Emotion Review*, 3(3), 305-307. doi: 10.1177/1754073911402373
- Deloitte Touche Tohmatsu Limited. (2014). Global health care outlook: Shared challenges, shared opportunities. London, UK.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* (4th ed.). Thousand Oaks, CA: SAGE Publications Inc.
- Doane, G. H., & Varcoe, C. (2013). Relational practice and nursing obligations. In J. L. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon* (2nd ed., pp. 143-159). Don Mills, ONT: Pearson.

- Doane, G. H., & Varcoe, C. (2014). *How to nurse: Relational inquiry with individuals and families in change health and health care context*. Philadelphia, PA: Wolters Kluwer, Lippincott Williams & Wilkins.
- Dodek, P. M., Hamric, A. B., Ayas, N., Dhingra, V., Heppell, L., Keenan, S., . . . Rodney, P. (2012, May 18 - 23, 2012). *Moral Distress In ICU Professionals Is Associated With Profession And Years Of Experience*. Paper presented at the American Thoracic Society International Conference, San Francisco, CA.
- Doige, N. (2007). *The brain that changes itself*. New York, NY: Viking.
- Edelman, G. M. (1993). Neural Darwinism: Selection and reentrant signaling in higher brain function. *Neuron*, *10*(2), 115-125. doi: 10.1016/0896-6273(93)90304-A
- Elder- Vass, D. (2008). Integrating institutional, relational and embodied structure: an emergentist perspective. *The British Journal of Sociology*, *59*(2), 281-299. doi: 10.1111/j.1468-4446.2008.00194.x
- Elpern, E. H., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care*, *14*(6), 523-530.
- Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics*, *20*(4), 330-342.
- Erikson, E. H. (1997). *The life cycle completed: Extended version*. New York, NY: Norton.

- Finset, A. (2012). "I am worried, Doctor!" Emotions in the doctor-patient relationship. *Patient Education & Counseling*, 88, 359-363. doi: 10.1016/j.pec.2012.06.022
- Flanagan, O. (1991). *Varieties of moral personality: Ethics and psychological realism*. Cambridge, MA: Harvard University Press.
- Flanagan, O. (1996). *Neuroscience, agency, and the meaning of life Self expressions: Mind, morals, and the meaning of life*. New York, NY: Oxford University Press.
- Flanagan, O. J. (1982). Virtue, sex, and gender: Some philosophical reflections on the moral psychology debate. *Ethics*, 92(3), 499-512. doi: 10.1086/292358
- Fourie, C. (2015). Moral distress and moral conflict in clinical ethics. *Bioethics*, 29(2), 91-97. doi: 10.1111/bioe.12064
- Francis, R. (2013a). Letter to the Secretary of State. In *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary* (pp. 3-5). London.
- Francis, R. (2013b). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary. UK: House of Commons.
- Freire, P. (2010). *Pedagogy of the oppressed*. New York, NY: Continuum.
- Fry, S. T., Harvey, R. M., Hurley, A. C., & Foley, B. J. (2002). Development of a model of moral distress in military nursing. *Nursing Ethics*, 9(4), 373-387.
- Gadow, S. (1999). Relational narrative: The postmodern turn in nursing ethics. *Scholarly inquiry for Nursing Practice*, 13(1), 57-70.

- Gardner, A. (2010). Therapeutic friendliness and the development of therapeutic leverage by mental health nurses in community rehabilitation settings. *Contemporary Nurse, 34*(2), 140-148.
- Gaudine, A. P., & Beaton, M. R. (2002). Employed to go against one's values: nurse managers' accounts of ethical conflict with their organizations. *The Canadian Journal of Nursing Research, 34*(2), 17-34.
- Gentles, S. J., Jack, S. M., Nicholas, D. B., & McKibbin, K. A. (2014). A critical approach to reflexivity in grounded theory. *The Qualitative Report, 19*, 1-14.
- Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard Press.
- Glaser, B. (1978). *Theoretical Sensitivity*. Mill Valley, CA: The Sociology Press.
- Glaser, B. (2002). Constructivist grounded theory? *FQS Forum: Qualitative social research, 3*(3), 1-14.
- Glaser, B. (2006). The roots of grounded theory. *The grounded theory review, 5*(2).
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New Jersey, USA: Aldine Transactions.
- Goldenberg, M. J. (2006). On evidence and evidence-based medicine: Lessons from the philosophy of science. *Social Science & Medicine, 62*(11), 2621-2632.
- Greene, J. (2003). From neural 'is' to moral 'ought': what are the moral implications of neuroscientific moral psychology? *Neuroscience, 4*, 847-850.

- Greene, J. (2014). The rise of moral cognition. *Cognition*, 135, 39-42. doi: 10.1016/j.cognition.2014.11.018
- Greene, J., & Haidt, J. (2002). How (and when) does moral judgment work? *TRENDS in Cognitive Science*, 6(12), 517-523.
- Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing*, 45(12), 535-542.
- Gunnar, M. R. (1998). Quality of early care and buffering of neuroendocrine stress reactions: Potential effects on the developing human brain. *Preventive medicine*, 27(2), 208-211. doi: 10.1006/pmed.1998.0276
- Gutierrez, K. M. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, 24(5), 229-241.
- Hall, W. A., & Callery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research*, 11(2), 257-272. doi: 10.1177/104973201129119082
- Hamaideh, S. H. (2014). Moral distress and its correlates among mental health nurses in Jordan. *International Journal of Mental Health Nursing*, 23(1), 33-41. doi: doi: 10.1111/inm.12000
- Hamric, A. B. (2012). Empirical research on moral distress: Issues, challenges, and opportunities. *HEC Forum*, 24(1), 39-49. doi: 10.1007/s10730-012-9177-x
- 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

Hanna, D. R. (2004). Moral distress: the state of the science. *Research and Theory for Nursing Practice*, 18(1), 73-93.

Hanrahan, N. P., Aiken, L. H., McClaine, L., & Hanlon, A. L. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. *Issues in Mental Health Nursing*, 31(3), 198-207. doi: 10.3109/01612840903200068

Hart, S. E. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship*, 37(2), 173-177. doi: 10.1111/j.1547-5069.2005.00030.x

Hayter, M. (2013). The UK Francis Report: The key messages for nursing. *Journal of advanced nursing*, 69(8), e1-e3. doi: 10.1111/jan.12206

Health Canada, & Public Health Agency of Canada. (2016). *Evaluation of mental health and mental illness activities of Health Canada and the Public Health Agency of Canada, 2010-2011 to 2014-2015*. Ottawa, ON: Health Canada Retrieved from <https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/evaluation/2010-2011-2014-2015-mental-health-mental-illness-activities-health-canada-public-health-agency-canada.html - exec>.

Heyland, D. K., Cook, D. J., Rocker, G. M., Dodek, P. M., Kutsogiannis, D. J., Skrobik, Y., . . . Cohen, S. R. (2010). Defining priorities for improving end-

- of-life care in Canada. *CMAJ : Canadian Medical Association Journal*, 182(16), E747-E752. doi: 10.1503/cmaj.100131
- Hiskey, S. (2012). Time to re-evaluate the therapeutic relationship. *Mental Health Practice*, 15(5), 34-35.
- Ho, A. (2008). The individualist model of autonomy and the challenge of disability. *Journal of Bioethical Inquiry*, 5(2), 193-207. doi: 10.1007/s11673-007-9075-0
- Hoffmaster, B. (2001). Introduction. In B. F. Hoffmaster (Ed.), *Bioethics in social context* (pp. 1 - 11). Philadelphia, PA: Temple University Press.
- Houck, N. M., & Colbert, A. M. (2017). Patient Safety and Workplace Bullying: An Integrative Review. *Journal of Nursing Care Quality*, 32(2), 164-171. doi: 10.1097/NCQ.0000000000000209
- Huffman, D. M., & Rittenmeyer, L. (2012). How professional nurses working in hospital environments experience moral distress: A systematic review. *Critical Care Nursing Clinics of North America*, 24(1), 91-100. doi: 10.1016/j.ccell.2012.01.004
- Humphries, A., & Woods, M. (2016). A study of nurses' ethical climate perceptions: Compromising in an uncompromising environment. *Nursing Ethics*, 23(3), 265-276. doi: 10.1177/0969733014564101
- Hyatt, J. (2017). Recognizing moral disengagement and its impact on patient safety. *Journal of Nursing Regulation*, 7(4), 15-21.

- Jaggar, A. M. (1991). Feminist ethics: Projects, problems, prospects. In C. Card (Ed.), *Feminist Ethics* (pp. 78-104). Lawrence, Kansas: University of Kansas Press.
- Jameton, A. (1977). The nurse: When roles and rules conflict. *Hastings Center Report*, 7(4), 22-23.
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, New Jersey: Prentice-Hall Inc.
- Jameton, A. (1993). Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing*, 4(4), 542-551.
- Jameton, A. (2013). A reflection on moral distress in nursing together with a current application of the concept. *Bioethical Inquiry*, 10(3), 297-308. doi: 10.1007/s11673-013-9466-3
- Jameton, A., & Fowler, M. D. (1989). Ethical inquiry and the concept of research. *Advances in Nursing Science*, 11(3), 11-24.
- Jantzen, D. (2012). *Refining nursing practice: A grounded theory of how nurses learn to nurse well in the current health care milieu (Doctoral Dissertation)*. Faculty of Nursing. University of Alberta. Education and Research Archive. Retrieved from <http://hdl.handle.net/10402/era.29154>
- Johnson, R., & Cureton, A. (2017). Kant's moral philosophy. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Fall 2017 ed.). online.
- Jones, A. C. (2004). Transference and countertransference. *Perspectives in psychiatric care*, 40(1), 13-19. doi: org/10.1111/j.1744-6163.2004.00013.x

- Jonsdottir, H., Litchfield, M., & Pharris, M. D. (2004). The relational core of nursing practice as partnership. *Journal of advanced nursing*, 47(3), 241-248. doi: 10.1111/j.1365-2648.2004.03088_1.x
- Kahn, D., & Eide, P. (2008). Ethical issues in the qualitative researcher-participant relationship. *Nursing Ethics*, 15(2), 199-207. doi: 10.1177/0969733007086018
- Kakuma, R., Minas, H., Ginneken, v., Dal Poz, M. R., Desiraju, K., Morris, J. E., . . . Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet*, 378, 1654-1663. doi: 10.1016/S0140-6736(11)61270-1
- Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P., & Arnetz, B. (2004). Living with conflicts-ethical dilemmas and moral distress in the health care system. *Social Science & Medicine*, 58(6), 1075-1084. doi: 10.1016/S0277-9536(03)00279-X
- Kälvemark Sporrang, S., Arnetz, B., Hansson, M. G., Westerholm, P., & Höglund, A. T. (2007). Developing ethical competence in health care organizations. *Nursing Ethics*, 14(6), 825-837. doi: 10.1177/0969733007082142
- Kälvemark Sporrang, S., Höglund, A. T., & Arnetz, B. (2006). Measuring moral distress in pharmacy and clinical practice. *Nursing Ethics*, 13(4), 416-427. doi: 10.1191/0969733006ne880oa
- Karanikola, M. N. K., Albarran, J. W., Drigo, E., Giannakopoulou, M., Kalafati, M., Mpouzika, M., . . . Papathanassoglou, E. D. E. (2014). Moral distress, autonomy and nurse-physician collaboration among intensive care unit

- nurses in Italy. *Journal of Nursing Management*, 22(4), 472-484. doi: 10.1111/jonm.12046
- Karanikolos, M., Mladovsky, P., Cylus, J., Thomson, S., Basu, S., Stuckler, D., . . . McKee, M. (2013). Financial crisis, austerity, and health in Europe. *Lancet*, 381, 1323-1331. doi: 10.1016/S0140-6736(13)60102-6
- Kays, J. L., Hurley, R. A., & Taber, K. H. (2012). The dynamic brain: Neuroplasticity and mental health. *The Journal of neuropsychiatry and clinical neurosciences*, 24(2), 118-124.
- Kelly, B. (1998). Preserving moral integrity: a follow-up study with new graduate nurses. *Journal of advanced nursing*, 28(5), 1134-1145. doi: 10.1046/j.1365-2648.1998.00810.x
- Kentikelenis, A., Karanikolos, M., Reeves, A., McKee, M., & Stuckler, D. (2014). Greece's health crisis: from austerity to denialism. *Lancet*, 383, 748-753.
- Kihlstrom, J. F. (2013). Threats to reason in moral judgment. *The Hedgehog Review*, 15(1), 8-18.
- Killen, M., & Smetana, J. (2008). Moral judgment and moral neuroscience: Intersections, definitions, and issues. *Child Development Perspectives*, 2(1), 6. doi: DOI:10.1111/j.1750-8606.2008.00033.x
- Kim, C. S., Spahlinger, D. A., & Billi, J. E. (2009). Creating value in health care: The case for Lean thinking. *Journal of Clinical Outcomes Management*, 16(12), 6.
- Kincheloe, J. L., McLaren, P., & Steinberg, S. R. (2011). Critical pedagogy and qualitative research: Moving to the bricolage. In N. K. Denzin & Y. S.

- Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4 ed., pp. 163-177). Thousand Oaks, CA: SAGE.
- Kohlberg, L. (2008/1963). The development of children's orientations toward a moral order. *Human Development, 51*(1), 11-33. doi: 10.1159/000112530
- Kothari, A., & Wathen, C. N. (2013). A critical second look at integrated knowledge translation. *Health Policy, 109*, 187-191. doi: 10.1016/j.healthpol.2012.11.004
- Krautscheid, L., DeMeester, D. A., Orton, V., Smith, A., Livingston, C., & McLennon, S. M. (2017). Moral distress and associated factors among baccalaureate nursing students: A multisite descriptive study. *Nursing Education Perspectives, 38*(6), 313-319. doi: 10.1097/01.NEP.0000000000000214
- Kuhn, T. (1977). Objectivity, value judgment, and theory choice. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on philosophy of science in nursing* (pp. 34-45). Philadelphia, PA: Lippincott Williams & Wilkins.
- Lapsley, D., & Carlo, G. (2014). Moral development at the crossroads: new trends and possible futures. *Developmental psychology, 50*(1), 1-7. doi: 10.1037/a0035225
- Lawler, J. (1997). Knowing the body and embodiment: methodologies, discourses and nursing. In J. Lawler (Ed.), *The body in nursing* (pp. 31-52). South Melbourne, Australia: Churchill Livingstone.
- LeDoux, J. (2003). The emotional brain, fear, and the amygdala. *Cellular and Molecular Neurobiology, 23*(4), 727-738. doi: 10.1023/A:1025048802629

- LeDoux, J. E. (1993). Emotional memory systems in the brain. *Behavioural Brain Research*, 58(1), 69-79. doi: 10.1016/0166-4328(93)90091-4
- Levine, P. A. (1997). *Waking the Tiger*. Berkeley, CA: North Atlantic Books.
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4th ed., pp. 97-128). Thousand Oaks, CA: SAGE Publications Inc.
- Lind, M., Kaltiala-Heino, R., Suominen, T., Leino-Kilpi, H., & Välimäki, M. (2004). Nurses' ethical perceptions about coercion. *Journal of Psychiatric and Mental Health Nursing*, 11(4), 379-385. doi: 10.1111/j.1365-2850.2004.00715.x
- Littlejohn, C. (2003). Critical realism and psychiatric nursing: a philosophical inquiry. *Journal of Advanced Nursing*, 43(5), 449-456. doi: 10.1046/j.1365-2648.2003.02742.x
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. *Clinical Psychology Review*, 29(8), 695-706. doi: 10.1016/j.cpr.2009.07.003
- Lützcén, K., & Kvist, B. E. (2012). Moral distress: A comparative analysis of theoretical understandings and inter-related concepts. *HEC Forum*, 24(1), 13-25. doi: 10.1007/s10730-012-9178-9

- Lutzen, K., & Schreiber, R. (1998). Moral Survival in a Nontherapeutic Environment *Issues in Mental Health Nursing, 19*(4), 303-315. doi: 10.1080/016128498248953
- MacDonald, M. (2001). Finding a critical perspective in grounded theory. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 113-158). New York, NY: Springer.
- Mack, C. (2013). When moral wncertainty becomes moral distress. *Narrative Inquiry in Bioethics., 3*(2), 106-109. doi: 10.1353/nib.2013.0037
- Maiden, J., Georges, J. M., & Connelly, C. D. (2011). Moral distress, compassion fatigue, and perceptions about medication errors in Certified Critical Care Nurses. *Dimensions of Critical Care Nursing, 30*(6), 339-345. doi: 10.1097/DCC.0b013e31822fab2a
- Mänttari- van der Kuip, M. (2016). Moral distress among social workers: The role of insufficient resources. *International Journal of Social Welfare, 25*(1), 86-97. doi: 10.1111/ijsw.12163
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*(1), 397-422. doi: 10.1146/annurev.psych.52.1.397
- Mate, G. (2011). *When the body says no: Exploring the stress-disease connection*. Hoboken, New Jersey: John Wiley & Sons.
- Maté, G. (2003). *When the body says no: The hidden cost of stress*. Toronto, On: Vintage Canada.

- Matier, C. (2012). *Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability*. Ottawa, ON: Office of the Parliamentary Budget Officer,.
- McCarthy, J., & Deady, R. (2008). Moral distress reconsidered. *Nursing Ethics*, 15(2), 254-262. doi: 10.1177/0969733007086023
- McEvoy, P., & Richards, D. (2003). Critical realism: A way forward for evaluation research in nursing? *Journal of Advanced Nursing.*, 43(4), 411-420. doi: 10.1046/j.1365-2648.2003.02730.x
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Author.
- Mental Health Commission of Canada. (2016). *Towards creating a mental health action plan for Canada: Roundtable report - 2015*. Mental Health Commission of Canada Retrieved from <https://www.mentalhealthcommission.ca/English/framework-action-2017-2022>.
- Mental Health Commission of Canada. (2018). *Mental health matters*. Retrieved February 24, 2018, from <https://www.mentalhealthcommission.ca/English/focus-areas/mental-health-matters>
- Milliken, A. (2018). Refining moral agency: Insights from moral psychology and moral philosophy. *Nursing Philosophy*, 19(1), 1-6. doi: 10.1111/nup.12185

- Milliken, P. J., & Schreiber, R. (2012). Examining the nexus between grounded theory and symbolic interactionism. *International Journal of Qualitative Methods*, 11(5), 684-696.
- Health Professions Act, Chapter 183 (2014a).
- Ministry of Health. (2014b). *Ministry of Health: 2014/15 - 2016/17 Service Plan*. Victoria, BC: Ministry of Health.
- Ministry of Health. (2014c). *Setting priorities for the B.C. health system*. Victoria: British Columbia.
- Ministry of Health Services, & Ministry of Child and Family Development. (2010). *Healthy minds, health people: A ten-year plan to address mental health and substance use in British Columbia*. Victoria, BC.
- Mitton, C., Peacock, S., Storch, J., Smith, N., & Cornelissen, E. (2010). Moral distress among healthcare managers: Conditions, consequences and potential responses. *Healthcare Policy*, 6(2), 99-112.
- Mitton, C., Peacock, S., Storch, J., Smith, N., & Cornelissen, E. (2011). Moral distress among health system managers: Exploratory research in two British Columbia health authorities. *Health Care Analysis*, 19(2), 107-121.
doi: 10.1007/s10728-010-0145-9
- Moffic, H. S. (2014). Reviewing retirement [Psychiatrist Steven Moffic - 1-year post-retirement]. Retrieved from <http://www.psychiatrictimes.com/blogs/couch-crisis/classic-blog-reviewing-retirement?GUID=5978AD60-E320-42FC-8127-5A97E1E5B7B9&rememberme=1&ts=22022014>

- Moll, J., & de Oliveira-Souza, R. (2007). Moral judgments, emotions and the utilitarian brain. *Trends in Cognitive Sciences*, 11(8), 319-321. doi: 10.1016/j.tics.2007.06.001
- Moll, J., de Oliveira-Souza, R., & Eslinger, P. J. (2003). Morals and the human brain: a working model. *Neuroreport*, 14(3), 299-305. doi: 10.1097/00001756-200303030-00001
- Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2017). What is 'moral distress'? A narrative synthesis of the literature. *Nursing Ethics*, 17. doi: 10.1177/0969733017724354
- Mruck, K., & Mey, G. (2007). Grounded Theory and Reflexivity. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 515-538). London, England: SAGE Publications.
- Munhall, P. L. (2007). Ethical considerations in qualitative research. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (4 ed., pp. 501-514). Sudbury, MA: Jones and Bartlett Publishers.
- Musto, L. (2010). *Doing the best I can do: Moral distress in adolescent mental health nursing*. (MN Research), University of Victoria, Victoria, British Columbia.
- Musto, L., & Rodney, P. (2018). What we know about moral distress. In C. Ulrich & C. Grady (Eds.), *Moral distress in the health professions* (pp. 9-20): Springer International Publishing AG.

- Musto, L., Rodney, P., & Vanderheide, R. (2015). Toward interventions in moral distress: Navigating reciprocity between structure and agency. *Nursing Ethics, 22*(1). doi: 10.1177/0969733014534879
- Musto, L., & Schreiber, R. S. (2012). Doing the best I can do: moral distress in adolescent mental health nursing. *Issues in Mental Health Nursing, 33*(3), 137-144. doi: 10.3109/01612840.2011.641069
- Musto, L. C., & Rodney, P. A. (2016). Moving from conceptual ambiguity to knowledgeable action: using a critical realist approach to studying moral distress: Critical realism and moral distress. *Nursing Philosophy, 17*(2), 75-87. doi: 10.1111/nup.12104
- Nairn, S. (2012). A critical realist approach to knowledge: implications for evidence-based practice in and beyond nursing. *Nursing Inquiry, 19*(1), 6-17. doi: 10.1111/j.1440-1800.2011.00566.x
- Narvaez, D. (2014). *Neurobiology and the development of human morality*. New York, NY: W.W. Norton & Company Inc.
- Niemeijer, A. R., & Visse, M. A. (2016). Challenging standard concepts of 'humane' care through relational auto-ethnography. *Social Inclusion, 4*(4), 168-175. doi: 10.17645/si.v4i4.704
- Nunokoosing, K. (2005). The problems with interviews. *Qualitative Health Research, 15*(5), 698-706. doi: 10.1177/1049732304273903
- Nuttgens, S., & Chang, J. (2013). Moral distress within the supervisory relationship: Implications for practice and research. *Counselor Education and Supervision, 52*(4), 284-296. doi: 10.1002/j.1556-6978.2013.00043.x

- Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., . . .
Narita, Y. (2010). Moral distress experienced by psychiatric nurses in
Japan. *Nursing Ethics*, 17(6), 726-740. doi: 10.1177/0969733010379178
- Orchard, C., Sonibare, O., Morse, A., Collins, J., & Al-Hamad, A. (2017).
Collaborative leadership, part 1: The nurse leader's role within
interprofessional teams. *Canadian Journal of Nursing Leadership*., 14-25.
doi: 10.12927/cjnl.2017.25257
- Oxford University Press. (1998). *Illustrated Oxford Dictionary* (1 ed.). New York,
NY: Oxford University Press.
- Pauly, B. (2013). Challenging health inequities: Enacting social justice in nursing
practice. In J. L. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a
moral horizon* (2 ed., pp. 430-447). Toronto, ON: Pearson.
- Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses'
perceptions of moral distress and ethical climate. *Nursing Ethics*, 16(5),
561-573. doi: 10.1177/0969733009106649
- Pauly, B. M., Varcoe, C., & Storch, J. (2012). Framing the Issues: Moral Distress
in Health Care. *HEC Forum*, 24(1), 1-11. doi: 10.1007/s10730-012-9176-y
- Pawson, R. (2002). Evidence-based policy: The promise of 'Realist Synthesis'.
Evaluation, 8(3), 340-358.
- Pawson, R., & Tilley, N. (2004). *Realist evaluation*. London, UK: SAGE
Publications.
- Pendry, P. S. (2007). Moral distress: Recognizing it to retain nurses. *Nursing
Economics*, 25(4), 217-221.

- Peplau, H. E. (1952). *Interpersonal relations in nursing: a conceptual frame of reference for psychodynamic nursing*. New York, NY Putnam.
- Perry, B. D. (2004). Maltreatment and the developing child: How early childhood experience shapes child and culture. *The Margaret McCain Lecture Series*, 6.
- Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14(4), 240-255. doi: 10.1080/15325020903004350
- Peter, E. (2011). Discourse: Fostering social justice: The possibilities of a socially connected model of moral agency. *Canadian Journal of Nursing Research*, 42(2), 11-17.
- 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. doi: 10.1007/s11673-013-9456-5
- Pickering, C. E. Z., Nurenberg, K., & Schiamberg, L. (2017). Recognizing and responding to the "toxic" work environment: Worker safety, patient safety, and abuse/neglect in nursing homes. *Qualitative Health Research*, 27(12), 1870-1881. doi: 10.1177/1049732317723889
- Pittenger, C., & Duman, R. S. (2008). Stress, depression, and neuroplasticity: A Convergence of mechanisms. *Neuropsychopharmacology*, 33(1), 88-109. doi: 10.1038/sj.npp.1301574

- Polifroni, E. C., & Welch, M. (1999). Nursing and philosophy of science: Connections and disconnections. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on Philosophy of Science in Nursing* (pp. 1-11). Philadelphia, PA: Lippincott.
- Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L., & Olsen, S. (2010). Compassion fatigue and burnout. *Clinical Journal of Oncology Nursing*, *14*(5), E56-62. doi: 10.1188/10.CJON.E56-E62
- Ray, S. L. (2006). Embodiment and embodied engagement: Central concerns for the nursing care of contemporary peacekeepers suffering from psychological trauma. *Perspectives in Psychiatric Care*, *42*(2), 106-113. doi: 10.1111/j.1744-6163.2006.00047.x
- Read, A. (2009). Psychiatric deinstitutionalization in BC: Negative consequences and possible solutions. *University of British Columbia Medical Journal*, *1*(1), 2.
- Reay, D. (1996). Dealing with difficult differences: Reflexivity and social class in feminist research. *Feminism & Psychology*, *6*(3), 443-456. doi: 10.1177/0959353596063007
- Regan, S., Laschinger, H. K. S., & Wong, C. A. (2016). The influence of empowerment, authentic leadership, and professional practice environments on nurses' perceived interprofessional collaboration. *Journal of Nursing Management*, *24*(1), E54-E61. doi: 10.1111/jonm.12288

- Registered Nurses Association of Ontario. (2002). Establishing Therapeutic Relationships *Nursing Best Practice Guidelines*. Toronto, ON: Registered Nurses Association of Ontario.
- Robinson, J. R., Clements, K., & Land, C. (2003). Workplace stress among psychiatric nurses. *Journal of Psychosocial Nursing & Mental Health Services, 41*(4), 32.
- Rodney, P., Buckley, B., Street, A., Serrano, E., & Martin, L. A. (2013). The moral climate of nursing practice: Inquiry and action. In J. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 188-214). Toronto, ON: Pearson-Prentice Hall.
- Rodney, P., Burgess, M., Phillips, J. C., McPherson, G., & Brown, H. (2013). Our theoretical landscape. In J. L. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a Moral Horizon* (2nd ed.). Don Mills, ON: Pearson.
- Rodney, P., Harrigan, M., Jiwani, B., Burgess, M., & Phillips, J. C. (2013). A further landscape: Ethics in health care organizations and health/health care policy. In J. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon* (2nd ed., pp. 358-383). Toronto, ON: Pearson.
- Rodney, P., Kadyschuk, S., Liaschenko, J., Brown, H., Musto, L., & Snyder, N. (2013). Moral agency: Relational connections and supports. In J. Storch, P. Rodney & Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 160-187). Don Mills, Ontario: Pearson.

- Rodney, P., & Varcoe, C. (2012). Constrained agency: The social structure of nurses' work. In F. Bayis, B. Hoffmaster, S. Sherwin & K. Borgerson (Eds.), *Health care ethics in Canada* (3rd ed., pp. 97-114). Toronto, ONT: Nelson.
- Rodney, P. A. (2013). Seeing ourselves as moral agents in relation to our organizational and sociopolitical contexts. *Journal of Bioethical Inquiry*, 10(2). doi: 10.1007/s11673-013-9461-8
- Rogers, S., Babgi, A., & Gomez, C. (2008). Educational interventions in end-of-life care: part I: An educational intervention responding to the moral distress of NICU nurses provided by an ethics consultation team. *Advances in Neonatal Care*, 8(1), 56-65.
- Romanow, R., Silas, L., & Lewis, S. (January 16, 2012). Why medicare needs Ottawa, Op Ed. *The Globe and Mail*.
- Romanow, R. J. (2002). Building our values: The future of health care in Canada. Ottawa, ON: Privy Council.
- Rushton, C. H., Caldwell, M., & Kurtz, M. (2016). CE: Moral Distress: A Catalyst in Building Moral Resilience. *AJN, American Journal of Nursing*. doi: 10.1097/01.NAJ.0000484933.40476.5b
- Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2013a). Addressing Moral Distress: Application of a Framework to Palliative Care Practice. *Journal of palliative medicine*, 16(9), 1080-1088. doi: 10.1089/jpm.2013.0105

- Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2013b). A framework for understanding moral distress among palliative care clinicians. *Journal of palliative medicine, 16*(9), 1074-1079. doi: 10.1089/jpm.2012.0490
- Ryan, R. M., Kuhl, J., & Deci, E. L. (1997). Nature and autonomy: An organizational view of social and neurobiological aspects of self-regulation in behavior and development. *Development and Psychopathology, 9*, 701-728.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18*, 178-183.
- Sapolsky, R. M. (2004). *Why zebras don't get ulcers* (3rd ed.). New York, NY: Holt Paperback.
- Sauerland, J., Marotta, K., Peinemann, M. A., Berndt, A., & Robichaux, C. (2014). Assessing and addressing moral distress and ethical climate, Part 1. *Dimensions of Critical Care Nursing, 33*(4), 234-245. doi: 10.1097/DCC.0000000000000050
- Schaufeli, W. B., & Taris, T. W. (2005). The conceptualization and measurement of burnout: Common ground and worlds apart. *Work & Stress, 19*(3), 256-262. doi: 10.1080/02678370500385913
- Schenck, D. (1986). The texture of embodiment: Foundation for medical ethics. *Human Studies, 9*, 43-54.
- Schmid, A., Hoffman, L., Happ, M. B., Wolf, G. A., & DeVita, M. (2007). Failure to rescue: A literature review. *The Journal of Nursing Administration, 37*(4), 188-198. doi: 10.1097/01.NNA.0000266838.23814.65

- Schore, A. (2002). Dysregulation of the right brain: A fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder. *Australian and New Zealand Journal of Psychiatry, 36*, 9-30.
- Schore, A. (2005). Attachment, affect regulation, and the developing right brain: Linking developmental neuroscience to pediatrics. *Pediatrics in Review, 26*(5), 204-217.
- Schore, A. (October 2005). *Affect Regulation and the Repair of the Self*. Paper presented at the Affect Regulation and the Repair of Self, Santa Fe, NM.
- Schreiber, R. S. (2001a). The grounded theory club, or who needs an expert? In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 97-112). New York, NY: Springer.
- Schreiber, R. S. (2001b). The "How To" of grounded theory: Avoiding the pitfalls. In R. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-84). New York, NY: Springer Publishing Company.
- Schreiber, R. S., & Martin, W. (2013). New directions in grounded theory. In C. T. Beck (Ed.), *Routledge international handbook of qualitative nursing research* (pp. 183-202). New York, NY: Routledge.
- Severinsson, E., & Hummelvoll, J. K. (2001). Factors influencing job satisfaction and ethical dilemmas in acute psychiatric care. *Nursing & Health Sciences, 3*, 81-90. doi: 10.1046/j.1442-2018.2001.00076.x
- Severinsson, E., & Sand, A. (2010). Evaluation of clinical supervision and professional development of student nurses. *Journal of Nursing Management, 18*, 669-677. doi: 10.1111/j.1365-2834.2010.01146.x

- Sewell, W. H. (1992). A theory of structure: Duality, agency, and transformation. *The American Journal of Sociology*, 98(1), 1-29. doi: 10.1086/229967
- Shannon, V., & French, S. (2005). The impact of the re-engineered world of health-care in Canada on nursing and patient outcomes. *Nursing Inquiry*, 12(3), 231-239.
- Shay, J. (1994). *Achilles in Vietnam*. New York, NY: Scribner.
- Shay, J. (2010). From an unlicensed philosopher: Reflections on brain, mind, society, culture--each other's environments with equal "ontologic standing". *Annals of the New York Academy of Sciences*, 1208(1), 32-37. doi: 10.1111/j.1749-6632.2010.05797.x
- Shay, J. (2012). Moral Injury. *Intertexts*, 16(1), 57-66. doi: 10.1353/itx.2012.0000
- Sherwin, S. (1998). A relational approach to autonomy in health care. In S. Sherwin, F. Baylis, M. Bell, M. De Koninck, J. Downie, A. Lippman, M. Lock, W. Mitchinson, K. Pauly Morgan, J. Mosher & B. Parish (Eds.), *The politics of women's health: Exploring agency and autonomy* (pp. 19-47). Philadelphia, PA: Temple University Press.
- Sherwin, S., Baylis, F., Bell, M., De Koninck, M., Downie, J., Lippman, A., . . . Parish, B. (1998). *The politics of women's health: Exploring agency and autonomy*. Philadelphia, PA: Templeton University Press.
- Siegel, D. J. (2010). *The Mindful Therapist*. New York, NY: W.W. Norton & Company Inc.
- Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. (2nd ed.). New York, NY: Guildford Press.

- Simpson, K. R., Lyndon, A., & Ruhl, C. (2016). Consequences of inadequate staffing include missed care, potential failure to rescue, and job stress and dissatisfaction. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 45(4), 481-490. doi: 10.1016/j.jogn.2016.02.011
- Smith, M., & Khanlou, N. (2013). An analysis of Canadian psychiatric mental health nursing through the junctures of history, gender, nursing education, and quality of work life in Ontario, Manitoba, Alberta, and Saskatchewan. *ISRN Nursing*, 2013, 1-13. doi: org/10.1155/2013/184024
- Stanley, K. M. (2010). So many names for bad behavior? *South Carolina Nurse*, 17(1), 2.
- Steger, M. B., & Roy, R. K. (2010). *Neoliberalism: A very short introduction*. New York, NY: Oxford University Press.
- Stern, P. N., & Covan, E. K. (2001). Early grounded theory: Its processes and products. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 17-34). New York, NY: Springer Publishing Company.
- Storch, J. L. (2013). Background on moral terrain. In J. L. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon* (2 ed., pp. 1-19). Ottawa, ON: Pearson.
- Storch, J. L., Rodney, P., Pauly, B., Brown, H., & Starzomski, R. (2002). Listening to nurses' moral voices: Building a quality health care environment. *Canadian journal of nursing leadership*, 15(4), 7-15.
- Strauss, A. (1995a). Identity, biography, history, and symbolic representations. *Social Psychology Quarterly*, 58(1), 4-12. doi: 10.2307/2787139

- Strauss, A. (1995b). Notes on the nature and development of general theories. *Qualitative Inquiry*, 1(1), 7-18. doi: 10.1177/107780049500100102
- Strawbridge, J. D., Barrett, A. M., & Barlow, J. W. (2014). Interprofessional ethics and professionalism debates: Findings from a study involving physiotherapy and pharmacy students. *Journal of Interprofessional Care*, 28(1), 64-65. doi: 10.3109/13561820.2013.829423
- Thomas, T. A., & McCullough, L. B. (2015). A philosophical taxonomy of ethically significant moral distress. *Journal of Medicine and Philosophy*, 40(1), 102-120. doi: 10.1093/jmp/jhu048
- Thompson, S. (2010). Policing Vancouver's mentally ill: The disturbing truth. Executive Summary. Vancouver, BC: Vancouver Police Department.
- Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.
- Trudeau, M., Clarke, S. P., & Aiken, L. H. (2003). Failure to rescue [with Response]. *The American Journal of Nursing*, 103(9), 13.
- Udod, S. A. (2012). Process of seeking connectivity: social relations of power between staff nurses and nurse managers. *Nursing Leadership*, 25(4), 29-47. doi: 10.12927/cjnl.2012.23262
- Udod, S. A. (2014). Seeking connectivity in nurses' work environments: Advancing nurse empowerment theory. *Canadian Journal of Nursing Research*, 46(3), 110-127.
- Ulrich, C. M., Hamric, A. B., & Grady, C. (2010). Moral distress: A growing problem in the health professions? *Hastings Center Report*, 40(1), 20-22. doi: 10.1353/hcr.0.0222

- Underwood, N. (2006). The teenage brain. *The Walrus*, 49-57.
- Upshur, R. (2005). Looking for rules in a world of exceptions: Reflections on evidence-based practice. *Perspectives in biology and medicine*, 48(4), 477-489. doi: 10.1353/pbm.2005.0098
- Vancouver Police Department. (2013). Vancouver's mental health crisis: An update report (pp. 33): Vancouver Police Department.
- Varcoe, C., Pauly, B., Webster, G., & Storch, J. (2012). Moral distress: Tensions as springboards for action. *HEC Forum*, 24(1), 51-62. doi: 10.1007/s10730-012-9180-2
- Vessey, J. A., Demarco, R., & DiFazio, R. (2011). Bullying, harassment, and horizontal violence in the nursing workforce: the state of the science. *Annual Review of Nursing Research*, 28, 133.
- Vickers, M. H. (2012). A rhetorical portrayal of the sham face of organizational support. *Administrative Theory & Praxis*, 34(4), 533-556. doi: 10.2753/ATP1084-1806340402
- Villeneuve, M. J. (2017). *Public policy and Canadian nursing*. Toronto, Ontario: Canadian Scholars.
- Wainwright, S. P. (1997). A new paradigm for nursing: The potential of realism. *Journal of advanced nursing*, 26(6), 1262-1271. doi: 10.1111/j.1365-2648.1997.tb00821.x
- Walker, E. R. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. *JAMA Psychiatry (Chicago, Ill.)*. 72(4), 334-340. doi: 10.1001/jamapsychiatry.2014.2502

- Walker, M. U. (2004). Introduction. In P. DesAutels & M. U. Walker (Eds.), *Moral psychology: Feminist ethics and social theory*. Lanham, Maryland: Rowman & Littlefield Publisher.
- Wallbank, S. (2010). Effectiveness of individual clinical supervision for midwives and doctors in stress reduction: Findings from a pilot study. *Evidence Based Midwifery, 8*(2), 65-70.
- Webster, G., & Baylis, F., E. . (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-229). Hagerstown, MD: University Publishing Group.
- Welch, M. (2005). Pivotal moments in the therapeutic relationship. *International Journal of Mental Health Nursing, 14*, 161-165.
- Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2015). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship, 47*(2), 117-125. doi: 10.1111/jnu.12115
- Wiggleton, C., Petrusa, E., Loomis, K., Tarpley, J., Tarpley, M., O'Gorman, Mary Lou, & Miller, B. (2010). Medical students' experience of moral distress: Development of a web-based survey. *Academic Medicine, 85*(1), 111-117.
- Wilkinson, J. M. (1987). Moral distress in nursing practice: experience and effect. *Nursing forum, 23*(1), 16-29. doi: 10.1111/j.1744-6198.1987.tb00794.x
- Wilkinson, J. M. (1989). Moral distress: A labor and delivery nurse's experience. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 18*(6), 513-519. doi: 10.1111/j.1552-6909.1989.tb00503.x

- Wilson-Bates, F. (2008). Lost in transition: How a lack of capacity in the mental health system is failing Vancouver's mentally ill and draining police resources Vancouver, BC: Vancouver Police Board.
- Wocial, L., Ackerman, V., Leland, B., Benneyworth, B., Patel, V., Tong, Y., & Nitu, M. (2017). Paediatric ethics and communication excellence (PEACE) rounds: Decreasing moral distress and patient length of stay in the PICU. *HEC Forum, 29*, 75-91. doi: 10.1007/s10730-016-9313-0
- Wolpe, P. R. (2000). From bedside to boardroom: Sociological shifts and bioethics. *HEC Forum, 12*(3), 191-201.
- World Health Organization. (2013). Mental Health Action Plan. Geneva, Switzerland: WHO.
- Yeo, M. (1994). Interpretive bioethics. *Health and Canadian Society, 2*(1), 85-103.
- Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics, 14*(3), 344-359.

Appendix A Moral Distress Definitions

Table 2 Definitions of Moral Distress by Author/ Date

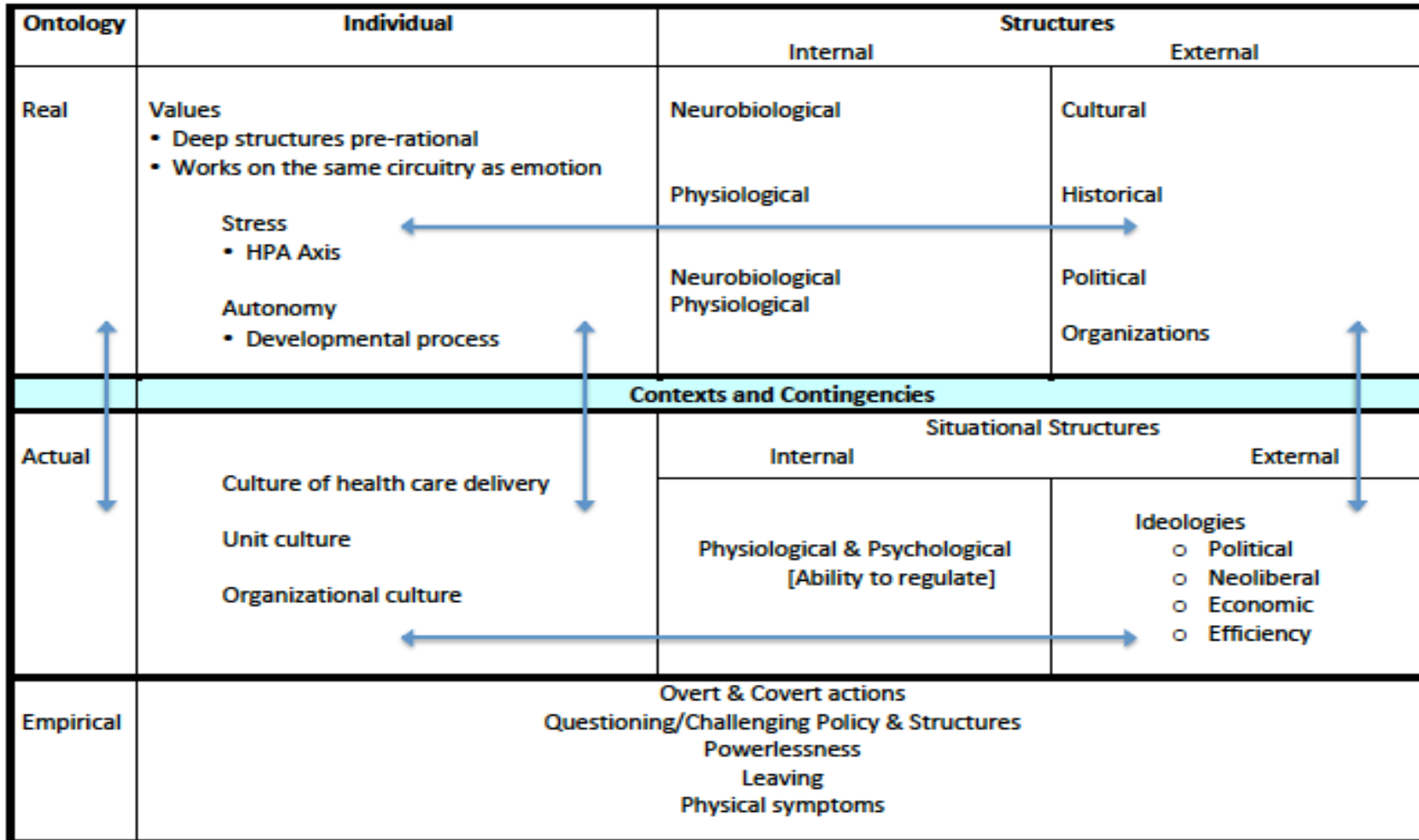
Authors	Definition
Jameton (1984)	Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action
Wilkinson (1988/89)	Psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision
Jameton (1993R)	<p>Initial moral distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values.</p> <p>Reactive moral distress is the distress people feel when they do not act upon their initial distress</p>
Hanna (2002)	The findings show that moral distress is an experiential phenomenon of pained recognition that occurs in the human response pattern of valuing. Based on the findings, the essence of moral distress is described as an experience of pained recognition of a human act that threatens, harms, or violates the moral end(s) of a living being, object, or situation. The experience of moral distress is multidimensional. It includes a combination of physical, emotional, social, and spiritual demands

Authors	Definition
Austin et al. (2003)	The state experienced when moral choices and actions are thwarted by constraints
Kälvemark et al. (2004)	Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake
Nathanial (2006)	Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, <i>either by act or omission</i> , in a manner he or she perceives to be morally wrong
Mitton et al. (2011)	Moral distress is the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet due to constraints (real or perceived) cannot carry out this action, thus committing a moral offence
Varcoe, Pauly, Webster, and Storch (2012)	The experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards

Authors	Definition
Rodney et al (2013)	What nurses (or any moral agents) experience when they are constrained from moving from moral choice to moral action – an experience associated with feelings of anger, frustration, guilt, and powerlessness
Crane, Bayl-Smith & Cartmill (2013)	The experience of psychological distress that results from engaging in, or failing to prevent, decisions or behaviours that transgress, or come to transgress, personally held moral, or ethical beliefs
Barlem & Ramos (2014)	The feeling of powerlessness experienced during power games in the micro-spaces of action, which lead the subject to a chain of events that impels him or her to accept imposed individualities, have his or her resistances reduced and few possibilities of moral action; this obstructs the process of moral deliberation, compromises advocacy, and moral sensitivity, which results in ethical, political, and advocational inexpressivity and a series of physical, psychical, and behavioural manifestations
Campbell, Ulrich, & Grady (2016)	One or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable

Appendix B Individual and Structures: Interactions

Figure 6 Interactions between Individuals and Structures



Appendix C Information Letter

Health Authority A

Health Authority B

Exploring Health Care Professionals perspectives on moving moral decisions to moral action

Principal Investigator: Patricia A. Rodney, Professor, School of Nursing, University of British Columbia

Graduate Student Researcher: Lynn C. Musto, Doctoral Candidate, School of Nursing, University of British Columbia

Information Letter About This Study

You are being invited to participate in this study because you are a Health Care Professional (HCP) currently working in the Mental Health Program. As a HCP working in mental health you have first hand experience of balancing organizational factors and patient needs in order to provide care that aligns with your professional Standards of Practice and Code of Ethics. We are inviting you to share your knowledge and experience with us by participating in the study.

We are conducting a study on how HCPs working in mental health turn moral decisions into moral action (the enactment of moral agency) when facing challenging ethical situations. Research in health care ethics suggests that difficulty turning moral decisions into moral action can have significant consequences for HCPs, health care organizations, and patient care. However, there is little research in the area of mental health care that explores this dimension of ethical decision-making. We also want to gain insight into aspects of the health care organization that help or hinder HCPs as they seek to turn moral decisions into moral actions.

How to be involved

Participation in this study can occur in two ways. Participants may choose to be involved one or two interviews. Participants may also elect to have me accompany them on a

“buddy” shift(s) so that we can learn about the environment and context in which they practice.

If you agree to participate in this study you will be asked to be involved in one or more interview(s) conducted by conducted by the Graduate Student Researcher, Lynn Musto. The initial interview will be approximately 45 – 90 minutes in length. As well, you may also participate in this study by allowing Lynn Musto to buddy with you for one or two shifts, or part of a shift, so that we may learn about working in acute mental health from different disciplinary perspectives. Being able to buddy with HCPs will help us learn how policy and health care structures influence professional practice.

Knowledge gained from this study will be used to develop recommendations for organizations and individuals that support HCPs as they face ethically challenging situations.

For further information

Thank you for your interest in this study. If you would like to participate in this study or would like more information, please contact

Thank you for your considerations in this study.

Dr. Patricia Rodney, *Associate Professor*,
University of British Columbia (UBC), School of Nursing

Appendix D Interview Schedule

Tell me about a situation you faced at work that you found ethically challenging.

Possible follow-up prompts:

And what happened then?

Tell me more about this.

What was it about this situation that you found ethically challenging?

What did you see as your options in this situation?

How did you respond to this situation? What did you do?

Were there options you felt weren't open to you?

What are/were your feelings regarding this situation?

What organizational factors influenced your ability to take the course of action you determined to be the most ethical?

- Examples of organizational factors include policies, vision and values statements, job description, spoken/unspoken expectations, position in the organization, organizational culture

What or who was helpful for you in this situation? What made it/him/her helpful?

What or who was unhelpful for you in this situation? What made it/him/her unhelpful?

What professional factors influenced your ability to take the course of action you determined to be the most ethical?

- Example of professional factors would be your Code of Ethics, Standards of Practice or other regulatory expectations

What, if any, expectations do you have of your work setting in the context of being able to practice in accordance with your Code of Ethics and Standards of Practice?

What advice would you give to a HCP who was came to you with a situation in which they were having difficulty determining what was ethically the right thing do?

Is there anything else I should know about the ethical decision-making that I didn't ask?

Appendix E Model

Risking Vulnerability: Enacting moral agency in the is/ought gap

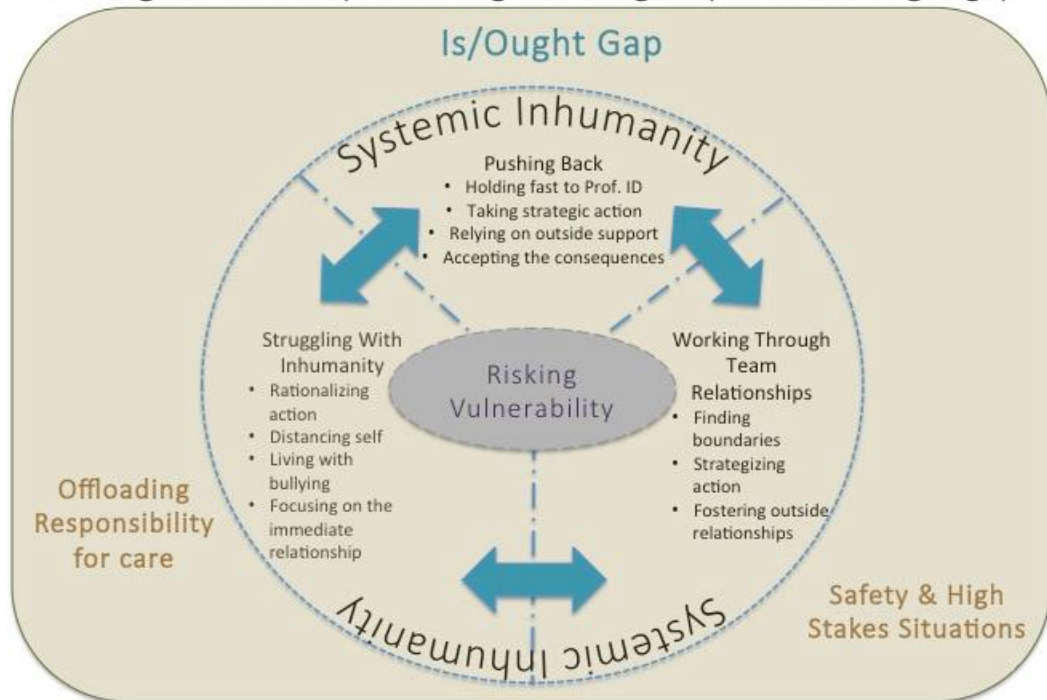


Figure 5.1 – Model of Categories of Action