



The case of Mr. J—Moral distress in a nurse and a physician

Mr. J is an elderly man in his 70s from a rural area. He worked at odd jobs in orchards and farms until he became chronically ill. He barely survives on Medicare and Medicaid, but a home health nurse visits several days a week. He has been followed as an outpatient for declining kidney function and multiple other problems. Although he has had progressive mental status changes, he consented to placement of a dialysis fistula three weeks before his first admission. Mr. J arrived on the renal unit hypotensive and in acute renal failure. The nephrologist explained to Mr. J that he needed emergency hemodialysis to survive. In his uremic state, Mr. J gave oral consent; no consent form was signed. No family was available at the time. Dialysis was begun.

When his primary care physician arrived soon afterward, Mr. J angrily said, “See what you started . . . I’m an old man and never wanted this!” However, Mr. J’s family was given hope for his survival with dialysis, and outpatient dialysis continued. The patient and his family have had a difficult time understanding how to manage his fluid restrictions and medical regimen.

Mr. J is readmitted, this time to the ICU, in pulmonary edema, congestive heart failure, and continued renal failure. He is intubated and sedated. When he awakens, he becomes agitated and his hands are restrained—he now has no say in his care. As his condition deteriorates, Mr. J develops vascular angioplasty with GI bleeding and anemia; he also suffers a stroke. He may require a bowel resection if/when he becomes stable.

The nurse

The nurse who cares for Mr. J on the renal unit is increasingly disturbed by the aggressive medical treatment given to him. She is concerned that Mr. J did not give informed consent to begin this trajectory. She believes that neither he nor his family has been given adequate information in an understandable way to be able to make an informed, autonomous, and noncoerced choice about treatment. She asks, "When a client has very little chance to survive, are the physicians being truthful and honest to the family? Do I proceed with the dialysis orders or ask the physician to explain the risks and benefits again in further detail?" As she checks Mr. J's restraints, she comments, "As a nurse, my hands are tied also."

The resident

The internal medicine resident is increasingly disturbed by the patient's continuing deterioration in the face of aggressive treatment. For the resident, however, informed consent is not a primary issue because the patient consented to placement of the fistula; beginning and continuing dialysis "really is the only option." From his perspective, the treatment choices have been appropriate given the patient's diagnoses, but he questions whether treatment is becoming futile. He asks, "Why are we even thinking about a bowel resection for Mr. J? His family could not manage him when he just needed dialysis. They don't understand how sick he is—they keep asking me when he can go home. Utilization review was up on the unit yesterday asking me questions about these orders I'm writing, because Mr. J has no insurance and they don't think Medicare will pay anywhere near what his care is costing the hospital. But the attending has gotten a surgery consult and insists we get him stable and operate. As a resident, my hands are tied also."

Moral distress in health care professionals What is it and what can we do about it?

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The Medical Center Hour is the University of Virginia School of Medicine's weekly multidisciplinary forum on medicine and society. Founded in 1971 by physician and former medical school Dean Thomas H. Hunter and pioneer medical ethicist Joseph Fletcher, Medical Center Hour frequently discusses issues in health care ethics and professionalism for a diverse audience of clinicians, professional students, faculty, and community residents.

This program on moral distress in health professionals, presented January 22, 2003, was a dialogue between Ann B. Hamric and Dr. Walter S. Davis, and was moderated by Marcia Day Childress.

Dr. Childress: Moral distress has only recently garnered scholarly attention in nursing, bioethics, and medicine. Clinicians may find the term "moral distress" new, but as our discussion unfolds they may realize that they have long been on intimate terms with its experience.

We frame this program about moral distress in clinical practice as a conversation between a nurse and a physician. Using the case of Mr. J as a touchstone,¹ Drs. Hamric and Davis discuss how moral distress challenges their everyday work in clinical ethics consultation and professional education, and what nurses and doctors can do about it.



**Moral distress—generated
by stymied frustration**

Dr. Hamric: First described by Andrew Jameton in a book on nursing ethics, moral distress occurs in a given situation when a health professional knows, or believes she knows, the ethically appropriate course of action to take but is unable to carry it out because of obstacles present.² Consider, for example, the nurse caring for Mr. J. She may believe it is unethical to continue aggressive treatment, but since her perspective is neither invited nor considered by the decision makers, she is expected to continue treating Mr. J, and does so despite her own beliefs. At the end of the case write up, she voices her mounting frustration and anger, her moral distress.

In the 20 years since Jameton's description, we have come to recognize moral distress as a common experience that is nonetheless poorly understood and rarely discussed, not only for nurses but also for physicians and other providers. While anecdotal literature on the subject has increased exponentially, only recently has moral distress been seriously studied within nursing. Over time, moral distress can compromise health professionals' moral integrity, a profoundly negative consequence that can, in turn, compromise the care they provide.

When I first used the idea of moral distress in lectures on nursing ethics, seasoned nurses would stay afterward to tell me their experiences. Their stories of moral distress, many 10 or 20 years old, were recalled in vivid detail. These nurses had never heard the term "moral distress," yet the concept resonated deeply with them and helped to make sense of their experience.

Dr. Davis: When Ann first called my attention to the phenomenon of moral distress, I knew immediately from my clinical ethics consultation and medical practice that moral distress is also experienced by physicians—in fact, by everyone on the health care team. It is the particular vulnerability of nurses, however, that can teach us the most about moral distress and how to manage it.

feels a nagging uncertainty, a sense that something is not quite right. The clinician experiencing moral uncertainty may stay silent—indeed, she may think that she alone is uncertain or may fear that she will look foolish if she asks questions.

In contrast, in situations of *moral distress* the clinician knows, or believes she knows, the ethically appropriate action, but feels constrained from acting because of some obstacle inherent in the situation, such as lack of time or supervisory support, institutional or legal constraints, or physician power over nursing and nursing practice. Based on my observations of clinicians, I extend Jameton's definition to include those who "believe they know" the ethically appropriate action, but are distressed because *the information they have is insufficient*.¹ Once these clinicians gain additional information clarifying the moral picture (for example, from other providers, the patient, or family members), their distress goes away.

Frustration, anger, anxiety, guilt, compromised integrity, and psychological disequilibrium characterize moral distress.^{3,4} Jameton distinguishes between *initial* moral distress, when the clinician first encounters the situation and senses, "This is wrong—I shouldn't be a party to this," and *reactive* distress, which the clinician feels about her own inability or failure to act on the initial distress.³ Clinicians who choose not to act may be morally distressed because they question whether they should have acted. But even those who act can become morally distressed, especially if dire consequences result—for instance, if something bad happens to the patient or if they suffer negative institutional sanctions.

Caregivers who suffer moral distress may be left with negative *moral residue*, distressing feelings that linger long after the situation if the caregiver feels regret or believes that she behaved unethically or betrayed important values.⁵ Negative moral residue can influence both a clinician's practice and her life.

The vertical hierarchies and steep power gradients of clinical care contribute to clinicians' experience of moral distress. The late physician William Bartholome recognized moral distress as an acute problem for those who feel relatively powerless in clinical decision making. He said,

moral distress is a very real problem . . . esp[ecially] in medical students, residents, nurses, respiratory care and other allied health workers . . . people who see themselves as involved in morally significant relationships with sick, vulnerable humans, but have little or no power to respond when what is happening appears to be "wrong."⁶



Jameton's three types of moral problems

Dr. Hamric: Jameton describes three types of moral problems affecting nurses: moral dilemma, moral uncertainty, and moral distress. The classic *moral dilemma* occurs when two or more opposing actions can be equally ethically justified and the agent, unable to carry out both actions, faces a dilemma in choosing which ethical course to follow. Clinical ethics education focuses on moral dilemmas, how to identify them, and explores the justifications for the opposing courses of action.

But Jameton notes two variants of this classic ethical picture.² *Moral uncertainty* occurs when the clinician does not know the ethically correct course, but



The diverse experiences

Dr. Davis: Nurses and physicians do not necessarily experience moral distress similarly

(Table 1). Both groups feel powerless to act ethically and feel that raising questions or speaking out when in moral distress is risky; it arouses their fears of criticism or negative sanction. However, different dynamics are at work in the two groups: inadequate informed consent triggers moral distress for the nurse caring for Mr. J, while the resident is distressed by the perceived futility of continuing aggressive treatment.

<ul style="list-style-type: none"> • Involves power differential and perceived powerlessness • Involves sense of risk in raising the question • Triggers that initiate moral distress may be different: 	
Nurse: <ul style="list-style-type: none"> – Differentiated from emotional distress – Initial versus reactive distress – Withdrawal as dominant reaction 	Physician: <ul style="list-style-type: none"> – Balance conflicts of conscience with professional expectations – Anxiety about increased scrutiny or questions of integrity – Anger as dominant reaction

The nurses

Dr. Hamric: Nurses frequently encounter situations that cause *emotional* distress but not *moral* distress—restraining Mr. J over his objections, for example, may be emotionally difficult for his nurse. But moral distress involves a perception that personal or professional values or core ethical obligations are being violated. Moral distress is thus more powerful than emotional distress, even though moral distress is always emotionally distressing.

A morally distressed nurse is in a quandary and feels powerless—as Mr. J’s nurse laments, “My hands are tied also.” Even when a nurse decides to speak up, he must deal with how to do so, because he is not in charge of the situation. It is not surprising, then, that withdrawal is nurses’ dominant reaction, with silence being the public face of initial moral distress. A nurse may then grapple with negative reactive distress as a result of not speaking up: not only did he compromise his own integrity by failing to take a stand, but his silence may have compromised the patient’s care. Sometimes a negative outcome occurs even when a nurse acts; second-guessing his actions, he then may struggle with negative moral residue.

The physicians

Dr. Davis: Like nurses, doctors in moral distress feel powerless and frustrated, especially when nonmedical concerns affect their decision making. Whether the constraining influence is hospital administration, government, or an insurance company, physicians are troubled by the fact that they do not always have the power to make the clinical decisions they deem appropriate. When the resident caring for Mr. J worries about the utilization review office or Medicare reimbursement influencing medical

decision making, he may also be thinking “I didn’t go into medicine to be prevented from providing good care.” He is feeling moral distress.

Moral distress also arises when a physician must balance conscience with professional expectations. What happens, for instance, if the ICU attending physician decides that Mr. J no longer needs intensive care but instead should receive palliative care? How does the intensivist little acquainted with palliative care then manage the gnawing concern that she may not be giving him appropriate care?

Physicians are anxious about all facets of their performance—decisions, documentation, outcomes—being subject to review. Also, in this era of “evidence-based medicine,” doctors may feel that their judgment and decisions are being ruled (or overruled) by the latest published reports.

Anger is the morally distressed physician’s dominant reaction, especially in situations in which the doctor may already feel overworked, stressed, or frustrated.



**Moral distress:
no happy outcome**

Dr. Davis: Moral distress in health professionals may cause emotional withdrawal from patients and coworkers, painful feelings such as anger, guilt, and depression, and even physical symptoms (Table 2).⁴ For nurses, moral distress may contribute to burnout or to departure from a position or even the profession. The angry outbursts of nurses and physicians in clinical settings may well have moral distress at their core, as may doctors’ quieter expressions of chronic frustration such as caustic attitudes toward or verbal abuse of students, residents, and nurses. A recent study (that did not mention moral distress by name) showed that disruptive physician behavior was a major influence on nurses’ satisfaction and retention.⁷

<ul style="list-style-type: none"> • Emotional withdrawal from patients and coworkers • Painful feelings, such as anger, guilt, depression, perhaps physical symptoms • For nurses, possibly having to leave a position or the profession • Perpetuation of power imbalances • Moral residue • For patients and their families: <ul style="list-style-type: none"> – Fragmented care, since care providers are frustrated – Emotionally withdrawn or angry care providers
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Dr. Hamric: We wonder how often moral distress in nurses goes unrecognized, its effects chalked up to lack of

time or burnout from overwork. Mary C. Corley's studies of two groups of ICU nurses are instructive. In her first study, 18 percent of the nurses surveyed had either considered quitting a position or had actually left because of moral distress. In the second study, 26 percent had left a previous position because of moral distress, a disturbing sign not only that this is a problem, but that it is an increasing one.^{4,8}

Bartholome noted

failure to acknowledge the frequency with which this experience is occurring in the clinical setting is a serious problem. And one of the most serious aspects of the problem is the tendency of those in power in the clinical setting (physicians et al.) to refuse to treat it as a serious problem.⁹

Factors generating moral distress

Dr. Davis: Sources of moral distress fall into three categories: clinical situations, factors internal to the caregiver, and factors external to the caregiver but inherent in the environment in which the moral distress occurs (Table 3).



Table 3. Sources of moral distress

Clinical situations	Internal factors	External factors
<ul style="list-style-type: none"> • Unnecessary treatment • Prolonging dying through aggressive treatment • Inadequate informed consent • Caregivers not as competent as care requires • Being "in the middle" 	<ul style="list-style-type: none"> • Perceived powerlessness • Lack of knowledge • Increased moral sensitivity • Lack of understanding the full situation 	<ul style="list-style-type: none"> • Institutional constraints/culture • Lack of time • Lack of administrative support • Policies and priorities and conflict with care needs • Compromised care due to pressures to reduce costs • Reimbursement constraints • Coworker issues/differing professional perspectives

Clinical situations

Moral distress is most common when a caregiver perceives care to be unnecessary, unwarranted, or futile. Mr. J's nurse feels that continuing aggressive treatment is only prolonging or delaying his dying, thus adding to the suffering of both patient and family.

Inadequate informed consent can create moral distress when a nurse or physician believes that the requirements of informed consent, such as decisional capacity, voluntariness, and disclosure of information have not been met. Most bioethicists consider informed consent more a "process" than an "event." But nurses and physicians-in-training are sometimes directed

to "consent" a patient by physicians who interpret this as getting the patient's signature (an event) and little appreciate what obtaining consent (a process) should entail.

Despite recent emphasis on quality assurance and avoidance of medical errors, there are, and always will be, nurses and physicians who are not competent to treat patients. When clinicians observe substandard performance or incompetence in a colleague, they may become distressed at having to choose among professional integrity, loyalty to coworkers, and keeping a stable work environment.

Dr. Hamric: Bioethicist H. Tristram Engelhardt, Jr., characterized nurses as "caught between" in describing a nurse's position midway between patient and physician, with obligations to both.¹⁰ While the nurse's primary duty is to the patient, she has other professional commitments, such as to the attending physician, her employing institution, and the nursing profession itself. Nurses can feel trapped by competing obligations, with tension over prioritizing and balancing commitments becoming a potent source of moral distress. However, being "in the middle" can also represent opportunities,¹¹ as when a team values collaboration and welcomes the nurse's contributions of patient information, with the result that the patient's care may improve.

Dr. Davis: Medical students and residents are also "caught between" attending physicians and patients and their families. While physicians-in-training often know the patient and family well and gather much of the information the team needs to formulate a care plan, they find themselves marginalized at decision making time. Their moral distress may result from being expected to implement a treatment plan contrary to their ethical beliefs.

Internal factors

Dr. Hamric: Nurses' perception of their powerlessness is a dominant theme underlying their unwillingness or inability to resolve ethical problems. The power differential between nurses and doctors can be both a barrier to good care and a source of moral distress. A clinician's lack of knowledge can also be a source of moral distress, as when nurses who are not up to date on managing pain in terminally ill patients become morally distressed when caring for such patients; once they understand new approaches to treat pain and suffering, their distress usually diminishes or disappears.

Corley maintains that increased moral sensitivity reduces moral distress, since sensitive providers should be more committed to patients and more morally competent.⁴ In our experience, however, heightened moral sensitivity itself can be a source of moral distress. Nurses with keen moral sensitivity to the ethical dimensions of care will experience distress if they see the moral dimension of nursing being neither respected, discussed, nor managed. Thus, in a perverse way, moral sensitivity in clinicians can put them at risk for moral distress. In one study of patient advocacy among nurses, 40 percent of those who

scored highest on advocacy had left the profession; one reason was moral distress.¹²

Dr. Davis: Medical schools seek to recruit students with moral sensitivity, students who previously have worked with and been responsive to vulnerable patients. Unfortunately, as medical education proceeds, we don't always give students permission or moral space to express and explore their reactions to vexing situations. Indeed, on some clinical rotations, students may learn that expression of ethical concerns is neither valued nor relevant and steals time from the "real" work of doctoring. As students graduate to residency and then move into practice, there is often a blunting of moral sensitivity that is revealed in the way they approach (or avoid) difficult ethical situations.

Dr. Hamric: Observing this phenomenon in nurses, Daniel F. Chambliss terms it "routinization" of the moral world. With experience, nurses can become insensitive—they no longer see the ethical problems under their noses. As Chambliss remarks, "The great ethical danger . . . is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing a decision at all."¹³

Dr. Davis: Finally, for nurse or physician, not understanding the full situation in a complex case can be a source of moral distress. Each caregiver may know only a portion of the patient's story or be unaware of events that took place when he or she was absent. If partial information provokes moral distress, though, the distress may dissipate once all facts are known.

External factors

Dr. Hamric: The nursing literature focuses on institutional constraints as sources of moral distress. Corley found inadequate staffing the primary source of moral distress for ICU nurses.⁸ This constraint goes hand in hand with lack of time. Lack of administrative support is a similarly powerful source of distress, as clinicians may feel it a waste of time and energy to voice concerns to unsympathetic or unresponsive administrators. Even well-intentioned institutional policies and priorities may conflict with patient care needs and cause clinicians distress.

Dr. Davis: Physicians become morally distressed when institutional or third-party payer pressures to contain or reduce costs seem to compromise patient care. The whole team may feel this at times, but because physicians sign the orders, they may feel acute pressure and resent their decisions being under scrutiny. The doctor's documentation in the patient's chart must justify payment for care, yet many qualitative influences on clinical decision making—among them, family and social dynamics—are difficult to explain in the medical chart. Physicians may then feel insurers' refusals to pay are unjustifiably depriving patients of care they need.

Issues arising among coworkers with different professional perspectives can cause moral distress. The various professionals in a patient care unit—physicians at different stages of training,

nurses, respiratory therapists, social workers, chaplains, and others who have contact with patients and families—have all been through their own fields' distinct educational and socialization processes; they speak separate languages, in a sense, and ascribe to different professional codes.¹⁴ For a multidisciplinary team, communication is a top priority, but even when communication is good, individual perspectives can be at odds, and dissonances may amplify in a crisis, leaving individual caregivers morally distressed.



Dealing with moral distress—strategies for relief

Dr. Hamric: What can we do about moral distress? The problem is sufficiently costly that we must develop strategies that directly address its sources and prevent its consequences (Table 4).

Initial steps
<ul style="list-style-type: none"> • Recognize and name moral distress when it occurs • Increase self-awareness of strengths and weaknesses • Speak up—insist on dialogue with other parties in the situation • Get the whole story
Identify the values in conflict
<ul style="list-style-type: none"> • Whose values? • Relationship to the patient?
Address root causes, when possible

Moral distress must be noted and named when and where it happens. Learning about moral distress, nurses say things like, "What a relief it is to hear that this is a real problem that other people experience, that it wasn't just me."

Dr. Davis: We must diagnose moral distress in ourselves and our colleagues much as we diagnose our patients' medical conditions. In ethics consultation, if everyone is looking for the ethical dilemma but the real issue is moral distress, we may misdiagnose and fail to treat the problem. Strategies for "treating" moral distress are not necessarily the same as reasoning through a moral dilemma.

Increasing clinicians' self-awareness, especially of their strengths and weaknesses, is crucial. Each of us also must learn to give and receive feedback in a way that promotes honest, open discussion; it is not helpful when we retreat to our respective disciplinary camps and withdraw from patients and each other. Physicians especially may find it challenging to hear what other team members, particularly nonphysicians, have to say about their performance, but the rewards of open exchange can be great. When a physician can hear and openly discuss criticism of her practice or professional behavior, an atmosphere is created in

which the moral distress of other team members decreases. And physicians may find their own moral distress diminishing when they understand their own roles in creating it for others.

Speaking up within the team is an obligation for every health professional and an important first step in dealing with moral distress. We must learn to talk about what makes us ethically queasy. Raising ethical concerns in a way that is neither confrontational nor disrespectful is a skill well worth learning.

Dr. Hamric: For nurses, speaking up is essential. We must support nurses and help them to see that, if they stay silent, their perspectives and what they alone know about their patients will not be shared, perhaps to the detriment of the patients' care. Likewise, physicians-in-training and attendings need to speak up when they feel trapped by moral distress. Many physicians fear losing credibility and respect if they display anything other than steely resolve. However, doctors may gain collegial support by speaking up about their own moral distress, and, doing so, they may avoid the intense anger that is fueled by distress and undermines collegiality. If Mr. J's nurse and resident share their concerns, they might find common ground in their experience of moral distress, and this could lead to different decisions being made on behalf of Mr. J.

Dr. Davis: Physicians often think of their team responsibilities as beginning and ending on daily clinical rounds. What doctors may not notice on rounds, particularly when cases are complex and decisions difficult, are the perspectives of other team members. Being open and responsive to other team members and their contributions while on rounds is crucial to obtaining a more complete picture of the patient, which can guide decision making in a way that deals with or even prevents moral distress.

Dr. Hamric: Another strategy is to identify values in conflict in troubling situations. Whose values are we talking about in a particular case? The nurse caring for Mr. J during dialysis, for instance, or the physician-on-call who against his own better judgment admitted Mr. J to the ICU? In academic centers, teams are big and change often. Dozens of people can be involved in caring for a patient like Mr. J, so it is important to establish specific caregiver roles and to know their experiences with the patient and family.

Dr. Davis: The external causes we have discussed must be addressed if we are to minimize moral distress at an institutional level. "Lack of time" is a good example, since all clinicians struggle with it. We must look at how we spend our time and how we can foster better team communication. We may not have to hold long, drawn-out conferences to hear one another's perspectives; simply including nurses on rounds may lower their moral distress.

Dr. Hamric: Compelling data show that collaboration reduces patients' mortality, improves patient care, and shortens length of stay.¹⁵⁻¹⁷ Collaboration is the goal, and it is more than a nice thing to do—it is a moral imperative for all of us to build and work in respectful, effective teams. Mutual respect requires listening,

being open to all viewpoints, and respectfully soliciting others' views. Collaboration is enhanced when we avoid stereotyping one another (e.g., "Nurses care and doctors cure") in ways that suggest that one provider group is morally superior to another.¹⁴

Dr. Davis: We must create a team environment in which all professionals share responsibilities, burdens, and successes. This is not easy. If a case has a positive clinical outcome, it is easy to credit the whole team. If a positive outcome hinges on excellent communication between the patient and one practitioner, however, it is tempting to reward that one person. But this approach misses the contributions of the environment within which beneficial communication occurred, contributions made by the whole team.

Finally, we need to admit our mistakes. Physicians sometimes adopt a defensive, "circle the wagons" attitude to deal with medical errors, but this stance can compromise communication and cause moral distress in other team members, especially if they feel coerced into dishonesty with patients or families. Full disclosure and early admission of error can go a long way toward resolving communication problems. It can also reduce legal challenges.



Let's redesign our cultures of medical practice

The case of Mr. J illustrates moral distress in a nurse and a physician. Distressed for different reasons, this doctor and nurse could fail to understand one another's concerns and become quite alienated. But if the two professionals can appreciate and acknowledge their common experience of moral distress, the understanding that results can unite them, foster dialogue, and lead to more appropriate care for Mr. J.

Moral distress is serious business for both nurses and physicians. One physician we know argues that it is the most pervasive and pressing problem in academic health care. For physicians-in-training who are vulnerable to the power differential in medical hierarchies, experiences of moral distress can be seminal events that shape their practice for years to come. And moral distress in nurses can cause them to leave a position or even the profession, contributing further to the serious nursing shortage. Even more important for both doctors and nurses, the experience of moral distress can challenge and endanger an individual practitioner's moral integrity. A radical rethinking of the cultures in which we practice is imperative if we are to protect the moral integrity of all clinicians and ensure humanistic, excellent patient care. As Bartholome wisely observed, "One mark of moral progress in a community or society might well be the extent to which measures are taken to reduce the incidence of moral distress in members of that community."¹⁸

References

1. Hamric AB. Moral distress in everyday ethics. *Nurs Outlook* 2000; 48: 199–201.
2. Jameton A. *Nursing Practice: The Ethical Issues*. Englewood Cliffs (NJ): Prentice-Hall; 1984.
3. Jameton A. Dilemmas of Moral Distress: Moral Responsibility and Nursing Practice. *AWHONN's Clin Iss Perinatal Women's Health Nurs* 1993; 4: 542–51.
4. Corley MC. Nurse moral distress: A proposed theory and research agenda. *Nurs Ethics* 2002; 9: 636–50.
5. Webster GC, Baylis FE. Moral Residue. In: Rubin SB, Zoloth L, editors. *Margin of Error: The Ethics of Mistakes in the Practice of Medicine*. Hagerstown (MD): University Publishing Group; 2000: 217–30.
6. Bartholome W. Moral distress. *Medical College of Wisconsin bioethics discussions*. mcw-bioethics@post.its.mcw.edu. 1998; Dec 10.
7. Rosenstein AH. Nurse-physician relationships: Impact on nurse satisfaction and retention. *Am J Nurs* 2002; 102: 26–34.
8. Corley MC. Moral distress of critical care nurses. *Am J Crit Care* 1995; 4: 280–85.
9. Bartholome W. Moral distress. *Medical College of Wisconsin Bioethics Discussions*. mcw-bioethics@post.its.mcw.edu, 1998; Dec 12.
10. Engelhardt HT Jr. Physicians, Patients, Health Care Institutions—and the People in Between: Nurses. In: Bishop AH, Scudder JR Jr, editors. *Caring Curing Coping*. Birmingham (AL): University of Alabama Press; 1985: 62–79.
11. Hamric AB. Reflections on being in the middle. *Nurs Outlook* 2001; 49: 254–57.
12. Millette BE. Client advocacy and the moral orientation of nurses. *West J Nurs Res* 1993; 15: 607–18.
13. Chambliss DE. *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*. Chicago: University of Chicago Press; 1996: 59.
14. Shannon SE. The roots of interdisciplinary conflict around ethical issues. *Crit Care Clin N Am* 1997; 9: 13–27.
15. Knaus WA, Draper EA, Wagner DP, Zimmerman JE. An evaluation of outcome from intensive care in major medical centers. *Ann Intern Med* 1986; 104: 410–18.
16. Aiken LH, Smith HL, Lake ET. Lower Medicare mortality among a set of hospitals known for good nursing care. *Med Care* 1994; 32; 771–87.
17. Lassen AA, Fosbinder DM, Minton S, Robins MM. Nurse/physician collaborative practice: Improving health care quality while decreasing cost. *Nurs Econ* 1997; 15: 87–91.
18. Bartholome W. Moral distress. *Medical College of Wisconsin Bioethics Discussions*. mcw-bioethics@post.its.mcw.edu. 1998; Dec 11.

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Erica Aitken

Sisyphus

Sisyphus should have seen her
pushing hard, shouting for life—
This Hispanic woman so young
so slick with sweat
blood on the sheets

Empuje!

Hands clenched, she lies there shivering.

Hours stretch
she cries
she shudders against her own boulder
straining against size
against the shoulder stuck
on the sidewall of her pelvis.

She's tiring, she knows

when she looks up
and the rhythm strip shows
how the late decels gain
leading us to so easily say

She needs a Caesarian.

Majid Mohiuddin, M.D.

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