Is the Theory of Moral Reckoning in Nursing Ready for Modification?

Alvita Nathaniel, PhD, APRN, FNP-BC Professor Emerita
West Virginia University, School of Nursing

Abstract

This paper is a personal reflection on the original theory of moral reckoning in nursing, which seeks to answer the question, "Is the Theory of Moral Reckoning in Nursing Ready for Modification?" I was reminded recently to pick up some data I had gathered and left dormant about nurses' experiences with COVID-19. A question was posed to me about published modified grounded theories. This triggered me to think more about modifying my own theory of moral reckoning to make it more relevant, explanatory, and predictive in today's healthcare environment. In this paper, I share snippets of data I gathered a couple of years ago and bits of popular, empirical, and theoretical literature which both impel me toward modifying the existing theory.

Keywords: classic grounded theory, modifiability, rigor, relevance

I'm asking myself, "Is it time to modify the theory of moral reckoning in nursing?" In 2006, I published the theory of moral reckoning in nursing when I was a practicing nurse (Nathaniel, 2004, 2006). In the subsequent years, I left nursing practice and moved to full-time academia. During that time, the healthcare environment, and indeed the world, underwent tremendous challenges. A couple of years ago I asked myself if the theory of moral reckoning requires modification in order to remain relevant, so I gathered a pile of interview data. But I left the data lay and moved on to other tasks. Recently, I was triggered to think about this again when I received communication from an esteemed nursing researcher, educator, and author, asking if I knew of any published modifications of classic grounded theories that she could show her students. If modification is one of Glaser's (1978) four criteria for rigor, surely, we could find good examples. I didn't know of any off the top of my head, so I contacted a network of classic grounded theory experts from around the globe. No one has been able to offer an example of a published theory that had been modified after the original publication. (Many are modified during the thesis/dissertation phase, sometimes after the oral defense.) The person requesting the information had published two modifications of an original theory, but, otherwise, there seems to be a dramatic scarcity of published modifications (Beck, 1993, 2012, 2022). So, here I go— picking up where I left off a couple of years ago. This paper is not a modification of the theory. I commit to doing that in the near future. Rather, it is a glimpse at the original theory and some of the popular, empirical, and theoretical literature focusing on healthcare professionals' experiences during the COVID-19 pandemic. Illustrations in this paper listed as "personal communication" are from the data that I gathered before I moved on to other things. The purpose of this paper is simply to share with you some of my data and a sample of the literature that

nudges me toward modifying the theory. In order for you to understand why modifications to the theory may be needed, it is important to begin with a look at the original theory.

The original theory explains and predicts a three-stage process of moral reckoning. After being asked to describe a troubling patient experience, participant nurses in the original classic grounded theory research study reported that they began their professional lives in a stage of ease in which they were comfortable with rules and expectations. The work of nursing was fulfilling, and they knew what to expect. They were gaining technical skills and had a sense of at-homeness in the workplace. Internal and external values and expectations were congruent, and core values, professional norms, and institutional norms were complementary. The nurses reported that at some point they experienced a sudden and dramatic situational bind in a patient care situation in which their core beliefs came into irreconcilable conflict with social or institutional norms. For instance, one nurse was ordered to administer a dose of medication to a terminally ill patient that she thought would likely be lethal, another was ordered to forego lifesaving interventions on a premature newborn. These situational binds constituted critical junctures that forced each nurse out of the stage of ease and into the stage of resolution. At this point, the nurses attempted to resolve the conflict by choosing among conflicting values. Immediate and long-term resolution included either giving up or making a stand. Some performed actions that they considered reprehensible (giving up) and others refused to comply with orders that conflicted with their values (making a stand), and some eventually left the profession. The nurses then moved into the stage of reflection, during which time they repeatedly examined past beliefs, values, and actions. The stage of reflection sometimes lasted for many years with the nurses trying to make sense of their experiences through remembering, telling the story, examining conflicts, and living with the consequences.

The theory of moral reckoning was discovered during an arguably stable and predictable era of institutional health care. Then came the explosion of COVID-19 through which the entire worldwide healthcare system was stressed to the breaking point. The years 2020 and 2021, particularly, provide dramatic examples of moral reckoning, which worsened over time and led to moral exhaustion (Jetten & Allard, 2025). Serious moral and ethical problems were suddenly thrust upon nurses during the COVID-19 global pandemic–the consequences of which are not yet fully clear. Although other problems have been identified, published accounts of moral problems during the COVID-19 pandemic seem to cluster around three basic moral situational binds—1) circumstances that forced nurses to choose between their duty of care they owe to patients and the safety of themselves and their families, 2) constraints that made it impossible to meet professional and personal standards, and 3) heartbreaking distributive justice choices. These challenging circumstances were made more painful by nursing's ethical directives to practice with compassion, respect every person, honor a primary commitment to the patient, and promote, advocate for, and protect the rights, health and safety of the patient (American Nurses Association [ANA], 2015, 2025)—directives which were often impossible to follow during the pandemic because of the dire circumstances that nurses found themselves in. Additionally, subsequent quantitative research in the UK (and elsewhere) found that other professions were experiencing the same types of moral problems in the workplace (Bow et al., 2023).

I know from reading the literature and from talking with colleagues that healthcare professionals of all types juggled their moral/ethical professional duties in the face of COVID-19 against protecting their own health and the health of their families. We all remember that hospitals were overwhelmed with COVID-19 patients, and many were unable to provide adequate personal protection for their staff (Morley et al., 2020). Healthcare workers feared they

could become sick or expose their families, particularly if they were the sole support for children or dependent adult relatives. Evans (2020) reported that one nurse said, "It's killing us" (para. 9). Like many others, McKenna (2020) proposed that nurses' duty to care for patients is not absolute. In fact, the World Health Organization (International Council of Nurses [ICN], 2012, 2021) and the American Nurses Association (2015, 2025) both recognize that nurses and other healthcare workers should weigh their professional roles against obligations to their own health and safety and that of their families and friends. Nevertheless, the duty to care and a prohibition from abandoning patients has been ingrained in nurses. The conflict between the duty to care and personal safety placed many nurses in painful situational binds. One nurse wrote, "I faced whether or not to even continue to provide inpatient care with an immunosuppressed child at home" (Anonymous, personal communication, March 21, 2021). Another nurse worried because she was, herself, immunocompromised as a triple-negative breast cancer survivor (Antelo, 2020). One colleague moved out of her home in order to protect her family. Even when they continued to provide nursing care, many nurses experienced distress when they believed their care did not meet professional standards.

During the COVID-19 pandemic, nurses faced situational binds that forced them to violate their internalized self-concept of a "good nurse." Workplace deficiencies created circumstances in which nurses' professional values came into direct conflict with the realities of everyday nursing care. Hospitals were overwhelmed with droves of desperately ill patients. Nurses who were previously comfortable in their roles suddenly found themselves in intensive care settings for which they lacked experience. One study found that nurses in China believed they had neglected patient rights, insufficiently responded to urgency requirements of the situation, and failed to provide patients with necessary support and pain management (Jia et al.,

2021). Some Scandinavian nurses thought the social isolation forced upon them by COVID-19 policies decreased the quality of life and even shortened patients' lifespans, while others claimed that denying patients' rights to see their loved ones was morally indefensible (Ariander et al., 2024). These situational binds were created when the nurses were not able to practice at high standards because of external factors (Jia et al., 2021). Jia et al. interviewed one nurse who burst into tears on the job because "I was worried that I was not doing my job well." One nurse in the U.S. reported distress when families were forbidden to visit because caregivers did not receive proper instruction on care of drains, tubes, ostomies, medical equipment, and medication administration. Consequently, patients were unprepared for discharge, and some had to be readmitted. Another nurse attributed difficult end-of-life decisions to separation of patients and families. She wrote, "Without being present and seeing it for themselves, families seem to have a really hard time letting go, so do-not-resuscitate orders are not written." The nurse commented that when providing what seemed like futile care in these situations, nurses reach a point when "we feel as though we are doing things TO the patient, instead of FOR the patient" (Anonymous, personal communication, March 21, 2021)—not at all the ideal role of the nurse.

Triage decisions may present the most painful situational bind of all those experienced during the COVID-19 pandemic. Nurses experienced distress when resources such as intensive care beds, respirators, or oxygen were in short supply. Morley et al. (2020) correctly suggested that nurses and physicians found it extremely difficult to make decisions to deny treatment because of their own humanness, their professional socialization, and the professions' norms about saving lives, relieving suffering, and not abandoning patients. Distress was found to be most acute when life-sustaining resources were discontinued and reallocated to other patients who had better chances of survival. Withdrawing treatments such as ventilator support was

especially difficult when the nurse or physician believed that the treatment was keeping a patient alive (Morley et al., 2020). They believed that withdrawing or withholding treatment was not in what they considered to be in the patient's best interest (McKenna, 2020). Swazo et al. (2020) suggested that faced with extreme scarcity of resources, the theoretical risk of "sacrificing the most vulnerable patients" shook professionals' deep set ethical convictions.

Anecdotal stories suggest some ways that nurses reckoned with the situational binds in which they found themselves. Though they were working hard and struggling with organizational failures and personal pressures, some nurses felt their work was invisible and thankless work (Lewis et al., 2025), and some nurses quit their jobs because of the distress they experienced working with COVID-19 patients (Antelo, 2020; Bustan et al., 2020; Swazo et al., 2020). Two Italian nurses took their own lives—the ultimate expression of giving up (McKenna, 2020). Others made a stand through extraordinary measures to deliver care in the face of dire circumstances. One nurse supported a family member who had difficulty accepting her mother's impending death. According to another nurse who watched through a window in the hallway, the nurse "put on her PPE, entered the room, and dialed the daughter's number. She talked for a few minutes and then laid down on the floor and slid under the patient's bed so the woman could see her mother's face one last time" (Anonymous, personal communication, March 21, 2021). This nurse made a stand through her determination to give the best care possible. The literature seems to indicate that many nurses forge ahead in the face of moral and ethical problems. One nurse said, "Most of us are stuck, still trying to sift through that stage of resolution, or perhaps we are even intentionally avoiding reflection. It was like we were stuck in time, grieving for some sort of normal, but the world kept moving around us. This experience has changed us" (Anonymous, personal communication, March 21, 2021).

Stories of nurses during the COVID-19 pandemic include feelings of defeat, sorrow, guilt, regret, sleeplessness, anxiety, fear, irritability, outrage, and powerlessness (Anonymous, personal communication, March 20, 2021; Evans, 2020; Jia et al., 2021; Swazo et al., 2020). Some experienced frustrations that overflowed at home as well as problems with mental and physical health (Jia et al., 2021). Still engaged in the stage of reflection, the nurses have continued to thoughtfully examine beliefs, values, and actions through remembering, telling the story, examining conflicts, and living with the consequences. They continue to reflect on the moral problems they experienced and how they responded. Ruminate about what happened to them and what they should have done.

Classic grounded theories are supposed to explain and predict what is going on in people's lives. Experiences of nurses and other healthcare professionals during the pandemic align with theory of moral reckoning in nursing. The theory explains the process that occurs when external pressures require hard moral decisions. But the original theory does not take into account the extremes that nurses and other healthcare professionals experienced during the pandemic—it needs modification. I have committed to gathering more data, constantly comparing it, memoing, and seeing what emerges. I think it will be more conceptual and more explanatory for broader substantive areas.

References

American Nurses Assciation (ANA). (2015). *Code of ethics for nurses with interpretive-statements*. http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html

… . (2025). *Code of ethics for nurses with interpretive statements*.

Antelo, P. U. (2020). Nurse quits in emotional video after being sent to an active coronavirus

   testing floor. *Talentrecap*. Retrieved from https://talentrecap.com/nurse-quits-in-

   emotional-video-after-being-sent-to-an-active-coronavirus-testing-floor/

Beck, C.T. (1993). Teetering on the edge: A substantive theory of postpartum depression.

   Nursing Research, 42(1), 42-48.

Beck, C.T. (2012). Exemplar: Teetering on the edge: A second grounded theory modification. In

   Munhall, P.I ed. *Nursing Research: A Qualitative Perspective* (5th ed.). Jones & Bartlett,

   257–284.

Beck, C.T. (2022). Teetering on the edge: A third grounded theory modification of postpartum

   depression. *Advances in Nursing Science, 46*(1), 14–27.

Ariander, A., Olaison, A., Andersson, C., Sjodahl, R. N., & Kastbom, L. (2024). Etical

   challenges causing moral distress: Nursing home staff's experiences of working during

   the COVID-19 pandemic. *Scandinavian Journal of Primary Health Care*, *42*(2), 266–

   275. https://doi.org/https://doi.org/10.1080/02813432.2024.2308573

Bow, S. M. A., Shroder-Back, P., Norcliffe-Brown, D., Wilson, J., & Tahizib, F. (2023). Moral

   distress and injury in the public health professional workforce during the COVID- 19

   pandemic. *Journal of Public Health*, *45*(3), 697–705.

   https://doi.org/https://doi.org/10.1093/pubmed/fdad010

Bustan, S., Nacoti, M., Botbol-Baum, M., Fischkoff, K., Charon, R., Made, L., . . . Kritzinger, M.

   (2020). COVID 19: Ethical dilemmas in human lives. *Journal of Evaluation in Clinical

   Practice, 27*(3), 716–732. doi:10.1111/jep.13453

Evans, M. (2020). 'It's killing us': Doctors, nurses resigned on Christmas morning as COVID

cases continue to rise. *Long Beach Post News*. Retrieved from

https://lbpost.com/news/covid-19-christmas-cases-deaths-hospitalizations

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*.

Sociology Press.

International Counsil of Nurses (ICN). (2012). *The ICN code of ethics for nurses*.

https://www.icn.ch/sites/default/files/inline-

files/2012_ICN_Codeofethicsfornurses_%20eng.pdf

… . (2021). *The ICN code of ethics for nusres*. ICN_Code-of-Ethics_EN_Web.pdf.

Jetten, H., & Allard, E. (2025). The general experience and moral distress of nurses in the

sociocultural context of the intensive care unit and the COVID-19 pandemic: A focused

ethnography. *The Canadian Journal of Critical Care Nursing, 36*(1), 8–24.

https://doi.org/DOI: 10.5737/23688653-3618

Jia, Y., Chen, O., Xiao, Z., Xiao, J., Bian, J., & Jia, H. (2021). Nurses' ethical challenges caring

for people with COVID-19: A qualitative study. *Nursing Ethics, 28*(1), 33–45.

doi:10.1177/0969733020944453

Lewis, S., Willis, K., & Smallwood, N. (2025). The collecdtive experience of moral distress: A

qualitative analysis of perspectives of frontline health workers during COVID-19. *Ethics,*

and Humanities in Medicine, 20(1). https://doi.org/https://doi.org/10.1186/s13010-024-

00162-y

McKenna, H. (2020). Covid-19: Ethical issues for nurses. *International Journal of Nursing*

Studies, 110, 1–2. doi:10.1016/j.ijnurstu.2020.103673

Morley, G., Grady, C., McCarthy, J., & Ulrich, C. M. (2020). Covid-19: Ethical challenges for nurses. *Hastings Center Report, 50*(3), 35-39. doi:10.1002/hast.1110

Nathaniel, A. K. (2004). A grounded theory of moral reckoning in nursing. *Grounded Theory Review*, *4*(1).

Nathaniel, A. K. (2006). Moral reckoning in nursing. *West J Nurs Res*, *28*(4), 419-438; discussion 439-448.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16672631

Swazo, N. K., Talukder, M. M. H., & Ahsan, M. K. (2020). A Duty to treat? A Right to refrain? Bangladeshi physicians in moral dilemma during COVID-19. *Philosophy Ethics and Humanities in Medicine, 15*(1), 23. doi:10.1186/s13010-020-00091-6

For all inquiries, contact anathaniel@hsc.wvu.edu