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# A Grounded Theory of Moral Reckoning in Nursing

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## Abstract

Moral distress is a pervasive problem in nursing, contributing to nurses' emotional and physical health problems, loss of nurses' ethical integrity, dissatisfaction with the work of nursing, and loss of nurses from the workforce. The purpose of this research was twofold: 1) to further elucidate the experiences and consequences of professional nurses' moral distress and 2) to formulate a logical, systematic, and explanatory theory of moral distress and its consequences. METHOD: This Glaserian grounded theory study utilized volunteer and purposive sampling to recruit 21 registered nurses. Analysis of the data resulted in an original substantive theory of moral reckoning in nursing, which reaches further than the concept of moral distress, identifying a critical juncture in nurses' lives and better explaining a process that affects nurses and the health care that they deliver. Results: Moral reckoning in nursing consists of a three-stage process. After a novice period, the nurse experiences a Stage of Ease in which there is comfort in the workplace and congruence of internal and external values. Unexpectedly, a situational bind occurs in which the nurse's core beliefs come into irreconcilable conflict with social norms. This forces the nurse out of the Stage of Ease into the Stage of Resolution, in which the nurse either gives up or makes a stand. The nurse then moves into the Stage of Reflection in which beliefs, values, and actions are iteratively examined. The nurse tries to make sense of experiences through remembering, telling the story, examining conflicts, and living with the consequences. Implications: In today's complex health care system, nurses find themselves faced with morally troubling situations which if not resolved can lead to serious consequences for nurses, patients, and the health care system as a whole. This study sets the stage for further investigation on the human consequences of moral distress. Further, since moral reckoning impacts health, nurse leaders are challenged to identify opportunities to facilitate successful moral reckoning in the workplace through encouraging nurses to tell their stories, examine conflicts, and participate as partners in moral decision making.

## Significance

The investigator's curiosity was initially piqued by stories about nurses' experiences with moral distress in the workplace. Moral distress is the pain or anguish affecting the mind, body, or relationships resulting 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, either by act or omission, in a manner perceived by the nurse to be morally wrong (Jameton, 1984; Wilkinson, 1987-88; Nathaniel, 2003). According to extant literature, situations involving moral distress may be the most difficult problems facing nurses, resulting in unfavorable outcomes for both nurses and patients. Because of moral distress, nurses experience physical and psychological problems, sometimes for many years (Kelly, 1998; Wilkinson, 1987-88; Perkin, Young, Freier, Allen & Orr, 1997; Fenton, 1988; Davies, et al., 1996; Krishnasamy, 1999; Anderson, 1990). Reports of the number of nurses who experience moral distress vary. Redman & Fry reported that at least one-third of nurses in their study (n = 470) experienced moral distress (2000). Nearly fifty percent of nurses in another study (n = 760) reported that they had acted against their consciences in providing care to the terminally ill (Solomon, et al., 1993). Between 43 and 50 percent of nurses leave their units or leave nursing altogether after experiencing moral distress (Wilkinson, 1987-1988; Millette, 1994).

Extant literature also implies that moral distress affects the quality of nursing care when nurses distance themselves from patients, become emotionally unavailable, avoid going in patients' rooms, leave the unit, or leave nursing altogether (Viney, 1996; Davies et al., 1996; Krishnasamy, 1998; Fenton, 1988, Wilkerson, 1987-88; Corley, 1995; Millett, 1994; Redman & Fry, 2000). Between 12 and 50 percent of nurses leave nursing or change their practice site as a direct result of moral distress (Millette, 1994; Corley, 1995; Wilkinson, 1987-88). Thus, moral distress may be a factor in the present nursing shortage–a self-perpetuating downward spiral.

## Method

Grounded theory is an inductive method in which theory emerges from the data. It moves from the systematic collection of data in a substantive area to the development of a multivariate conceptual theory. To allow continued discovery and flexibility of exploration, as is appropriate to grounded theory research, this study began with the following broad research question that narrowed and redirected as the research progressed: What transpires in morally laden situations in which nurses experience distress? With advice and guidance of Dr. Barney Glaser, co-originator of the grounded theory method, the phenomenon of moral distress among professional nurses was explored and a substantive theory of moral reckoning emerged. The study was conducted in accordance with the original method as described by Glaser and Strauss (1967) and subsequently refined by Glaser (1978, 1996, 1998).

This study utilized a combination of nonprobability techniques of volunteer and purposive sampling as described by Chinn (1986). The purpose of nonprobability sampling is to describe, foster understanding, and elicit meaning. Participants were initially selected because they could shed light on the phenomenon under investigation. Subsequent sampling was related to the findings that emerged in the course of the study, with the process continuing until saturation was met. The investigator aspired to interview a broadly representative cohort of nurses. Participants were recruited through various means including an advertisement published a state nurses' association newsletter, distributed to nurse leaders for sharing with others, and posted at a state nurses' convention and regional nursing research conference. In the advertisement, nurses were asked to either email or call (toll-free) the principle investigator if he/she had ever been involved in a troubling patient care situation that caused distress. Neither gender nor minority groups were excluded. The target population included all registered nurses who had ever experienced distress in relation to a moral/ethical problem in a patient care situation. All those responding to the advertisement were interviewed until saturation of categories was reached.

Participants were interviewed in an unstructured casual manner. This provided an efficient, yet meaningful mix of interview, observation, and conceptualization. Initial interviews were conducted in person or over the telephone. Face-to-face interviews were conducted in quiet, private locations close to informants' homes. When face-to-face interviews were impracticable because of distance, interviews were conducted by the telephone or through email. No interviews were conducted in participants' work settings. As recommended by Glaser (1998), interviews were neither taped nor transcribed. Brief, unobtrusive contemporaneous notes were taken to ensure that field notes were factually correct. Field notes were written immediately following the interviews—usually within one hour.

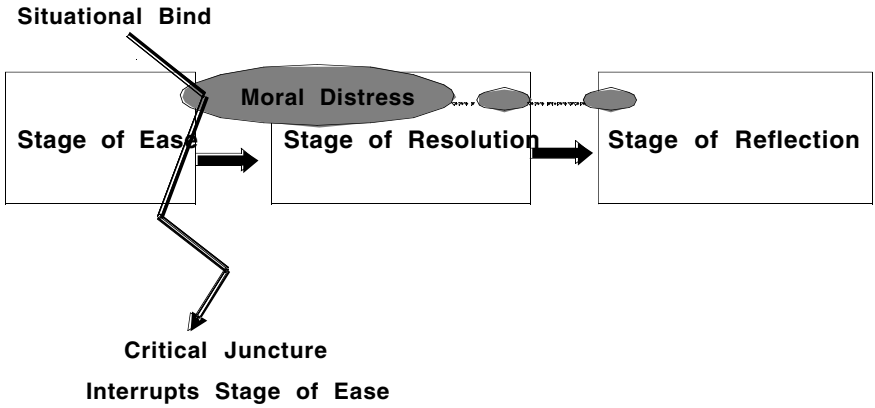
As is hallmark of the constant comparative method, analysis began with the first episode of data gathering and occurred simultaneously with other steps of the grounded theory process. Data were analyzed sentence by sentence and were then coded. The coded data were organized into concepts and further into categories, which were subsequently integrated into theory. Throughout the process, emerging ideas about concepts and processes were recorded in the form of conceptual memos. Theoretical sampling began when the investigator found categories that required more refinement or areas that need more depth. The core variable was identified when it emerged as the one to which all others related. As categories became saturated and the relationships among them became clear, the substantive Theory of Moral Reckoning in Nursing was found to effectively synthesize, organize, and transcend what was previously known about moral distress. During the final write-up, conceptual memos were organized and field notes were revisited to illustrate the newly discovered theory.

## Theory

The sample consisted of 21 registered nurses. Twenty were female and 17 were married. Informants were highly educated and experienced: 2 with associate degrees, 3 with bachelor degrees, 13 masters degrees, and 3 doctorates. Nineteen participants were Caucasian, 1 was Hispanic, and 1 Native American. Eighty percent had more than 10-year's professional experience. Forty-three percent reported that they had left a position because of a morally distressing situation.

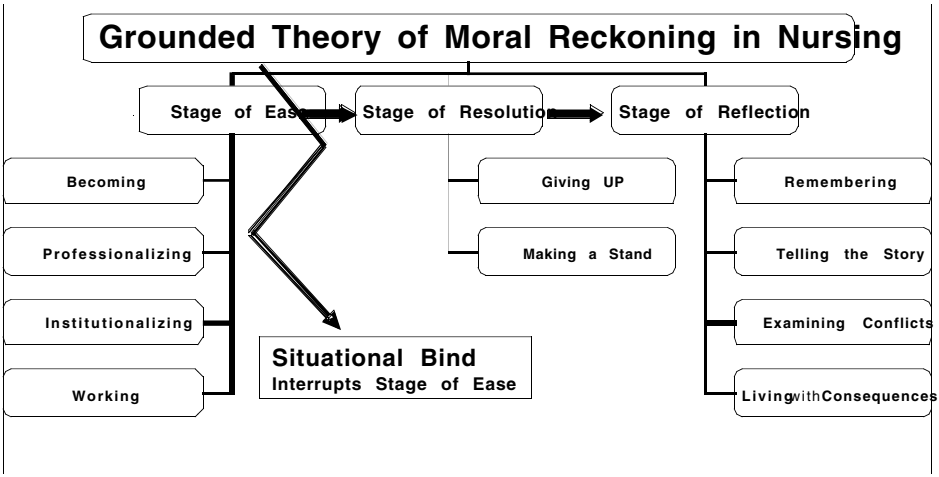
As the interviews were coded and compared, it became clear that moral distress, the original focus of the investigation, was not emerging as a major category. Specifically, the definition of moral distress in the literature is free from process connotations, includes a requirement that the nurse must participate in moral wrongdoing, and goes little further than to describe the psychological implications. The definition of moral distress also implied an adversarial relationship in which nurses are opposed by powerful wrongdoers. This definition was not supported by the data in the present study, so it constituted springboard for further investigation. As the data unfolded, new basic social psychological process of Moral Reckoning was discovered to be the core concept. Moral distress, as described in the extant literature, relates to three facets of the highly organized theory of moral reckoning as follows: Moral distress a) is triggered by a situational bind, b) overlaps a tiny portion of one stage of a larger process, and c) overlaps a larger segment of a basic social process. Figure 1 depicts the theory and its relationship to moral distress.

**Figure 1. Moral distress overlaps the process of Moral Reckoning**



Moral Reckoning, the core category, captures the culmination of the entire, three-stage process. It connotes a process during which nurses critically and emotionally reflect on motivations, choices, actions, and consequences of a particularly troubling patient care situation. To reckon is defined as follows: "To recount, relate, narrate, tell; to allege; to calculate, work out, decide the nature or value of; to consider, judge, or estimate by, or as the result of calculation; to consider, think, suppose, be of opinion; to speak or discourse of something; and to render or give an account (of one's conduct, etc)" (Simpson & Weiner, 1989, Vol. XIII, p. 335-336). The three distinct stages of Moral Reckoning are the Stages of Ease, the Stage of Resolution, and the Stage of Reflection. Each stage is comprised of unique properties. Figure 2, illustrates the grounded theory of moral reckoning with its stages and properties.

**Figure 2. Stages and properties of Moral Reckoning**




## Stage of Ease

Integral to the Stage of Ease are the properties of (a) becoming, which signifies an ongoing refinement of stable core beliefs and values of the individual, (b) professionalizing, which relates to inculcation of the professional norms, (c) institutionalizing, which signifies the process of internalizing institutional social norms, and (d) working, the unique experience of the work of nursing. As is noted in the following sections, conflict between and among the conditions during a critical incident produce a situational bind.

Each person evolves a set of core beliefs and values through the process of becoming. Core beliefs evolve over time through experience and from teaching and modeling of parents, teachers, ministers, peers, and so forth. Moral integrity indicates integration and consistency of core values over time (Beauchamp &

Childress, 2001). Evidence of participants' core beliefs emerged from their stories and included such indicators as their membership in a caring profession, their sense of responsibility to relieve suffering, their commitment to uphold professional and institutional norms, and the tumult that occurred when core beliefs were challenged.

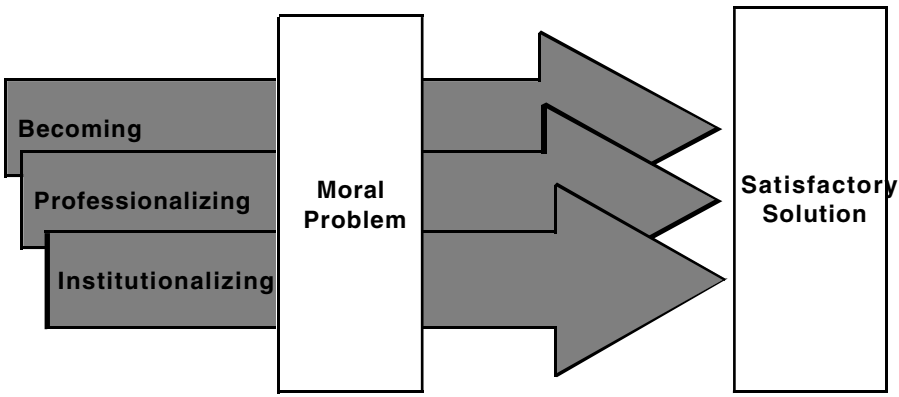
For nurses, professionalizing refers to inculcation of certain unique cultural norms learned in nursing school and early practice. Conceptual ideals that contribute to the nurse's idea of what a good nurse should be or do are considered professional norms. Nurses' professional norms complement core beliefs for the most part, so that the profession and professional norms become internalized and uniquely important to the person. Nurses learn explicitly that they have unique relationships with patients and that they are responsible to keep promises implicit in the relationship. Perceived professional norms include the following non-exclusive implicit rules: one must follow physicians' orders, complete assigned work with expert skill, and remain altruistic.

Through the process of institutionalizing, nurses are socialized within the institutional setting to a different set of implicit and explicit norms. Institutional norms are variably congruent with nurses' core beliefs and professional norms. For example, nurses learn to complete a job according to institutional standards and respect lines of authority. Assuring that the business makes a profit, following orders, handling crises without making waves, and covering are some implicit institutional norms. Speaking about her disappointment within the health care setting, one informant said, "Corporate is bigger than life itself."

Working is another condition of the first stage of Moral Reckoning. The unique work of nursing is varied, challenging, and rewarding and requires technical skill and attendance to many facets of patients' lives. Nurses work at "arm's length" (Penticuff, 1997) from patients as they attend to the most personal and private of needs. In the process, they learn tremendous amounts about patients' hopes, fears, and desires. They get to know patients who stay on their units for extended periods or return many times. Nurses hear what patients say and understand the meaning. They intimately know about suffering patients—from touch, sight, smell, and sound. Patients' interests, very clearly, become nurses' interests. Their descriptions of the work of nursing include vivid sensual descriptions and heart-wrenching stories. Doing the work of nursing includes the properties of knowing patients, witnessing suffering, accepting responsibility to care, desiring to do the work well, and knowing what to do. Held in fragile balance, the conditions of becoming, professionalizing, institutionalizing, and the work of nursing comprise the Stage of Ease. Nurses are motivated by core beliefs and values to uphold congruent professional and institutional norms during this stage. Having technical skills and feeling satisfied to practice within the boundaries of self, profession, and institution, nurses are comfortable, they

know what is expected of them and experience a sense of flow and at-homeness. One informant said, “Early in my career I was employed in the hospital setting and very conscientious about my work. I was very in-tune to the patients and their care, wanting to make sure that everything was done that was supposed to be done and that I completed all my work before the next shift came on. I loved the challenge of the medically difficult patient. I always did well in the emergencies—CPR, GI bleeds, chest pains, etc. After those first few months of new nurse jitters, I felt at ease and comfortable at my station....” The Stage of Ease is depicted in figure 3.

**Figure 3 During the Stage of Ease, moral problems in the presence of compatible core values and professional and/or institutional norms lead to satisfactory solutions.**




**Congruent Values in the Stage of Ease**

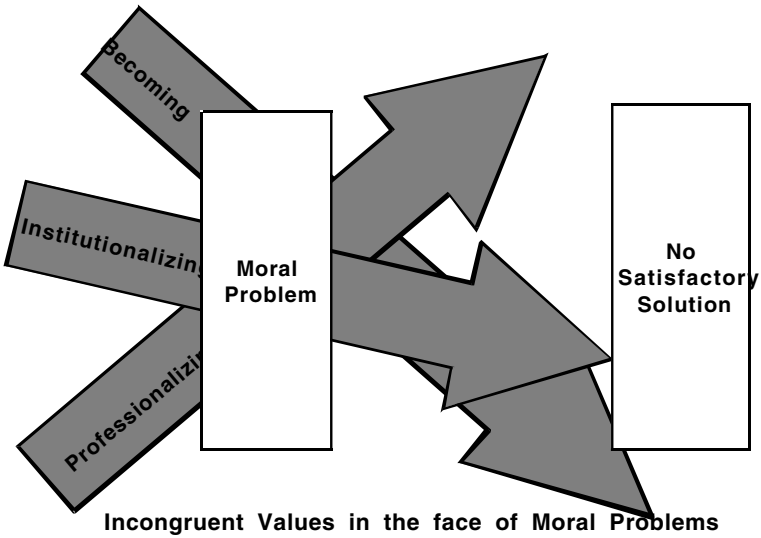
The Stage of Ease continues as long as the nurse experiences fulfillment with the work of nursing and comfort with the integration of core beliefs and professional and institutional norms. For some, a morally troubling event will challenge the integration of core beliefs with professional and institutional norms. Nurses find themselves in Situational Binds that herald a critical juncture in their professional lives.

## Situational Binds

A situational bind interrupts the Stage of Ease. Situational binds involve an intricate interweaving of many factors including professional relationships, divergent values, workplace demands, and other implications with moral overtones. Situational binds vary in their complexity, context, and particulars but

are similar in terms of their immediate and long-term effects. Nurses' turmoil may meet or exceed the traditional definitions of moral distress. Situational binds compel nurses to make difficult decisions and culminate in critical junctures in their lives. As depicted in figure 4, nurses feel constricted by binds involving conflicts with ethical/moral overtones that occur between core values, and professional or institutional norms or between nurses and others. When this happens, inner dialogue guides the nurse toward critical decisions in which he or she must choose one value or belief over another. Situational binds encountered by nurses in this study included intricate combinations of demands and conflicts with both moral and practical implications. Specific types of situational binds include conflicts between a) core values and professional or institutional norms, b) participants with imbalance of power, and c) nurses' values and workplace deficiencies: all of which lead to consequences for nurses and patients. Situational binds and their resolution constitute critical junctures as nurses moves toward the processes of resolution and reflection—the remaining stages of moral reckoning.

**Figure 4. During the Stage of Ease, moral problems in the presence of compatible core values and professional and/or institutional norms lead to satisfactory solutions.**




Professional or institutional norms may challenge core beliefs. This is evidenced when informants reveal core beliefs as they talked about the struggle to come to terms with conflicts involving professional or institutional norms. For example, one nurse is still troubled because she believes she tortured a patient when she

followed orders. The patient was a young woman for whom the physician had ordered "nothing by mouth." Through the day, the woman begged for something to drink. Following orders, the nurse refused to give the woman fluids. The young woman died the next day and the nurse still struggles with the "harm" she feels she caused the woman. In this case, the nurse was in a bind because the actions prescribed by the profession and institution (maintaining NPO status) conflicted with the nurse's commitment to relieving suffering, which seemed to her to be the morally correct action.

Situational binds are often the result of asymmetrical power relationships during morally troubling patient care situations. Many times, nurses believe they are excluded from the ethical decision-making process. They feel strongly that they have a duty to respect patients' wishes and to affect appropriate outcomes and they are frustrated when their attempts fail. For example, several informants voiced a sense of powerlessness in situations in which physicians and family members seemed to make important life decisions that were in conflict with autonomous patients' wishes. Specific decisions included performing surgery, inserting feeding tubes, and performing resuscitation. The nurses were strongly committed to patients' rights to make autonomous decisions, yet they were not able to successfully advocate for the patients' choices. Even though they tried to intervene, they felt great distress when patients suffered.

Power imbalance is also evident when physicians do not believe what nurses tell them. This is a frequent theme. Because nurses feel a strong sense of responsibility to patients and take seriously the implicit promise to relieve their suffering, they are frustrated when they attempt to communicate patients' wishes or status to physicians who will not listen. Informants talked about instances when physicians refused to come in to see patients, refused to order emergency medication, or disbelieved the nurses' assessment of patients' deteriorating conditions. One nurse talked about her distress when a series of consultants ignored her concerns about a patient's deteriorating condition following a gunshot wound to the neck. The patient died from a simple wound because physicians ignored the nurse's appeals.

Sometimes nurses perceive themselves to be in binds when there is no frank moral wrongdoing, but rather divergent core beliefs. When decision makers have legitimate beliefs that are different from the nurse, the nurse might believe that moral wrongdoing is occurring. For example, several informants denounced physicians who they believed coerced families or patients to make decisions consistent with the physicians' personal beliefs, but conflicting with the nurses' beliefs. In these cases, even though an objective bystander would not identify moral wrongdoing, the nurses felt a great deal of distress. Paradoxically, the two types of cases in which this was most dramatic included instituting life sustaining measures and allowing patients to die.

On occasion, nurses experience distress when deficiencies in the workplace lead to patient harm. Workplace deficiencies place nurses in situational binds because they challenge nurses' core values. Specific deficiencies identified in this study included chronic staff shortage, unreasonable institutional expectations, and equipment failure. For example, nurses can be overwhelmed by overly heavy patient care assignments. This constitutes a situational bind when a nurse is truly committed to providing care that meets professional and institutional standards, yet must care for more patients than he or she believes is safe. This leads to distress when the nurse cannot meet all of his or her own and others' expectations and lingering guilt about real or potential harm to patients. One nurse tearfully recalled a morning when a visitor had a cardiac arrest on her unit. The nurse was responsible for "working the code" while no one cared for her assigned patients. Years later, she continues to be troubled about the potential harm to patients who essentially had no nurse that day and by the violation of her own values.

There are consequences that occur as the result of situational binds. During the situational bind and for some time afterwards, nurses experience profound emotions and reactive behaviors directed toward themselves or others. Participants said they were "very torn," "bothered horribly," and "incredibly sad." They talked about feelings of guilt, anger, powerlessness, conflict, depression, outrage, betrayal, and devastation. They also experienced physical manifestations such as near syncope, crying, sleeplessness, and vomiting. Reactive behaviors included fleeing the unit, going into a rage, drinking alcohol, and sacrificing self.

Nursing care subsequent to situational binds is affected in a number of ways. Following morally troubling situations, nursing care may be negatively affected, unchanged, or improved. Different than extant reports of moral distress, very few informants in this study reported that their nursing care was negatively affected. One nurse was able to perform only routine tasks at the desk and called for a replacement within a couple of hours. Another said even though she had always loved her work, after a troubling incident she resigned because she believed her care would be affected. In contrast, most nurses reported that their nursing care improved as a direct result of a situational bind. Some reported that they were compelled to make up for what they considered to be harm resulting from others' moral wrongdoing by giving more compassionate care—even to the point of sacrificing themselves. One nurse talked about feeling compassion for the patient and trying to treat him with dignity. Others said that their care improved in the long term because they were better prepared to deal with situational binds. In any case, painful feelings and realizations about harm to patients propels nurses toward the Stage of Resolution.

## Stage of Resolution

Situational binds constitute crises of intolerable internal conflict and produce critical junctures in nurses' lives. In order to maintain moral integrity, something must be done immediately to rectify the situation. The move to set things right signifies the beginning of the Stage of Resolution. For most, this stage alters professional trajectory. There are two foundational choices in the Stage of Resolution: making a stand and giving up. These choices are not mutually exclusive. In fact, many nurses give up initially, regroup, and make a stand. Others make an unsuccessful stand and give up at a later time.

Some nurses resolve their distress by making a stand. All forms of making a stand include professional risk. Nurses make a stand when they initiate negotiations, refuse to follow physicians' orders, break the rules, whistle blow, and so forth. Making a stand is rarely successful in the short term, but may occasionally improve the overall situation in the long term. For example, informants made a stand when they refused to help with resuscitation of patients who had voiced their objection, to sign coerced surgical consent, and to administer potentially fatal doses of medication. Sadly, in every case, another nurse was willing to intervene and follow the questionable order.

In contrast, nurses may also resolve a situational bind by giving up. In general, nurses give up because they recognize the futility of making an overt stand. They are simply not willing to sacrifice themselves to no avail. They may also give up to protect themselves or to seek a way or find a place where they can live their ground projects with better integration of core beliefs, professional norms, and institutional norms. Specifically, giving up includes participating in an activity considered to be morally wrong, leaving the unit or resigning, or leaving the profession altogether. For example, a number of informants talked about feeling as if they have given up when, against their conscience, they administered medication in doses that they knew were likely to be lethal. This occurred almost exclusively when patients were dying. Nurses subsumed their core beliefs to institutional norms, which strongly favored following physicians' orders. They administered the medications with regret and resigned from their positions soon afterwards. Nurses do not pass through the Stage of Resolution unscathed, yet they do move forward—into the Stage of Reflection.

## Stage of Reflection

The Stage of Reflection may last a lifetime during which nurses reflect and reckon their actions. In most cases, the incidents nurses recall occurred early in their careers. During the Stage of Reflection nurses raise questions about prior judgments, particular acts, and the essential self. The interrelated properties of

the Stage of Reflection include remembering, telling the story, examining conflicts, and living with consequences.

One of the more intriguing properties of the Stage of Reflection is remembering. After situational binds nurses retain vivid mental pictures. These memories evoke emotions many years later. One nurse said, "I don't let go of it." Nurses experience sensual memories of the incident—memories of the sights, sounds, and smells. After 15 or 20 years, informants talked about patients' faces, exact locations of the patients' beds, and sometimes a patient's position in bed. Unlike their memories of other patients, nurses remember particulars about patients involved in morally troubling situations such as their names, ages, and diagnoses. For example, one nurse recalled that the patient was wrapping Christmas presents at home when she was injured. As she talked about his incident she called forth emotions as well as memories.

Nurses experience evoked emotion many years after the situational bind. Emotions that are evoked as nurses remember morally troubling situations include feelings of guilt and self-blame, lingering sadness, anger, and anxiety. Unlike descriptions of moral distress, nurses feel guilt and self-blame even when they did not actually participate in moral wrongdoing. They experience guilt related to the patient's outcome, rather than their own participation in a troubling event. Even when they report a series of events in which they are above reproach, informants continue to blame themselves for the harm that occurred to patients. Lingering effects include anxiety attacks, crying episodes, depression, and prolonged psychiatric care.

Nurses also continue to express anger toward those they believe were responsible for causing harm to patients. Physicians, other nurses, and institution administrators are targets of anger and blame. Anger harbored over many years leads to fracturing of professional relationships. For example, talking about a physician who did not respond during an emergency, one nurse said, "I still have no use for him."

Remembering is an iterative process with nurses continuing moral reckoning over time—telling the story as they try to make sense of it. Informants in the present study desired to tell their stories, volunteering to participate in hour-long interviews and later voicing gratitude for the chance to tell their stories. Telling their stories evoked emotions even though troubling patient situations may have occurred 15 to 20 years previously. Regardless of the interval between the incident and the telling of it—many wept as they talked about the incidents.

Remembering and telling their stories, nurses begin examining conflicts in the situations. They struggle as they examine conflicts between personal values and professional ideals. They examine their values and ask themselves questions about what actually happened, who was to blame, and how they can avoid

similar situations in the future. Thus, they move toward full-dimensional, reflective awareness of experiences, thoughts, feelings, emotions, and values.

As nurses think about their roles in what they consider past moral wrongdoing, some make practical decisions. They set limits or rules concerning future actions. They identify a point beyond which they will not go and some vow to take risks to help patients in the future.

Nurses experience living with the consequences for a prolonged period. Since they are no longer comfortable in the original workplace, nurses move from one institution to another or from one specialty area to another. They are likely to seek further education, often intending to correct the type of moral wrongs they experienced in the past. Many informants in this study attended graduate school subsequent to their morally troubling event. Few of them remain at the bedside, even though most talked about enjoying the work they were doing during the Stage of Ease.

## Discussion

The current study identifies a very powerful, yet heretofore unidentified basic social process. The theory is powerful because it has fit and relevance, and it works. Congruent with Glaser (1998), concepts and categories of Moral Reckoning emerged from stories told by nurses (fit); emergent concepts relate to true issues of the nurses interviewed (relevance); the stages account for most of the variation of nurses' behavior (work); and, the theory can be constantly modified to fit and work with relevance. Thus, this theory, which is rigorously grounded in data is easily understandable and imbues trust. Moral Reckoning is a new and original theory that establishes unique connections—making familiar ideas relevant, while giving integrative scope and a new perspective. Because the theory is very broad and overarching, it provides opportunities for future research that can move in many directions.

The theory calls for programs of research that will further explore and more fully develop its categories and concepts and begin to identify causes and make comparisons and predictions. Vigorous theoretical sampling is needed to 1) allow a more thorough and useful understanding of the stages of Ease, Resolution, and Reflection and different ways that nurses might progress through them, 2) provide a better understanding of core values as they intersect with professional and institutional norms, and 3) modify the theory to include different types of nurses.

In addition, nursing ethics research is needed to shed light on what nurses understand about nursing ethics, the depth of this understanding, how their understanding of nursing ethics factors into every day decision making, and what kinds of learning leads to empowered, patient-centered, ethical decision making. Further qualitative and quantitative research is also needed to

determine the characteristics of nurses who experience moral distress and moral reckoning versus those who do not and the quality of patient care provided by each group. Correlational research is needed to identify nurses who leave and those who stay, particularly in relation to whether or not they experience moral distress and moral reckoning. In the face of the nursing shortage, this has implications for nurse recruiting and retention. If, as the present study suggests, caring and sensitive nurses leave the bedside, it is important for research to identify strategies to retain them.

Research on moral reckoning should not be limited to the profession of nursing. The Grounded Theory of Moral Reckoning in Nursing easily lends itself to development of a formal grounded theory of moral reckoning—one that is generalizable to other substantive areas. Investigators have an opportunity to use the theory with other professions and to modify it for a wide variety of populations. It is an evocative theory, which has the power to widely inform practitioners and leaders about the realities of the struggle between personal moral convictions and collective decision making.

This new theory encompasses moral distress, but reaches further—identifying a critical juncture in nurses' lives and better explaining a process that includes motivation and conflict, resolution, and subsequent reflection. Based on the life experiences of nurses, the Grounded Theory of Moral Reckoning in Nursing is a powerful new theory that has fit, work, and reliability, and is easily modifiable. It transcends, organizes, and synthesizes the extant literature on moral distress, and explains stages of a newly identified basic social process, which is also relevant to many other substantive areas. It also offers important implications for nursing practice, education, and administration and, in the face of a nursing shortage of crisis proportions, presents urgent and unique opportunities for further investigation.

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