Notice to CNE enrollees:
A closed-book, multiple-choice examination following this article tests your understanding of the following objectives:
1. Identify common causes of moral distress in critical care nurses who are caring for dying patients.
2. Describe the concept of psychological empowerment and the 4 cognitions it encompasses.
3. Discuss the study findings as related to the relationship between moral distress intensity and frequency, psychological empowerment, and participant demographics.

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Background: Critical care nurses providing care for adults at the end of life may encounter moral distress when they cannot do what they believe is ethically correct. Psychological empowerment can decrease moral distress among critical care nurses.

Objectives: To describe the relationships between moral distress, psychological empowerment, and demographics in critical care nurses caring for patients at the end of life.

Method: A total of 277 critical care nurses were surveyed via the Moral Distress Scale and the Psychological Empowerment Instrument. Responses were scored on a Likert scale of 1 to 7.

Results: Moral distress intensity was high (mean 5.34, SD 1.32) and positively correlated with age (r = 0.179, P = .01). Moral distress frequency was moderate (mean 2.51, SD 0.87) and negatively correlated with nurses’ collaboration in end-of-life patient care conferences (r = -0.191, P = .007). Psychological empowerment scores (mean 5.31, SD 1.00) were high and positively correlated with age (r = 0.139, P = .03), years of experience (r = 0.165, P = .01), collaboration in end-of-life care conferences (r = 0.163, P = .01), and end-of-life-care education (r = 0.221, P = .001) and were negatively correlated with moral distress frequency (r = -0.194, P = .01). Multiple regression analysis revealed that empowerment was a significant predictor of moral distress frequency (β = .222, P < .01).

Conclusion: The significant negative correlation between psychological empowerment and frequency of moral distress in these nurses indicated that nurses with higher perceived empowerment experience moral distress less often. This finding is of particular interest as interventions to decrease moral distress are sought. (American Journal of Critical Care. 2013;22:143-152)
The advent of life-support technology during the past half century has drastically changed the focus of caring for dying patients. Critical care units were developed in order to monitor critically ill patients appropriately, and critical care nurses were provided specialized education for the purpose of providing optimal care for critically ill patients. Although advanced technology has brought with it the promise of more efficient treatment techniques, extending life inappropriately and futile prolonging of patients’ suffering have become commonplace for critical care nurses, thus causing moral distress in critical care nurses. Jameton was the first to define moral distress in the nursing literature. Moral distress was defined as discomfort or internal conflict related to ethical dilemmas encountered in nursing practice when constraints prevented the nurse from following the course of action believed to be right. Obstacles contributing to the inability to act upon what the nurse believes to be right have many origins. Beckstrand and Kirchhoff identified several obstacles that critical care nurses perceived while providing end-of-life care, including the perception that their opinions related to end-of-life care decisions were not being recognized and valued. The highest ranking obstacles in this study were as follows: Families not understanding the term “life-saving measures” and its implications, families requesting life-saving measures contrary to patients’ wishes, and patients’ treatments continuing although painful or uncomfortable.

In 2006, the American Association of Critical-Care Nurses (AACN) identified end-of-life care challenges as a significant source of moral distress in critical care nurses. AACN has issued a position statement on moral distress, proclaiming it a serious problem in nursing. Psychological empowerment is a mechanism by which people gain mastery of their affairs. In the nursing literature, empowerment has been examined on the basis of 2 conceptualizations, structural and psychological. Psychological empowerment (one’s belief in one’s ability to be empowered) was measured in this study.

As critical care nurses develop a more active voice in collaboration with physicians, ethics committees, and members of the multidisciplinary health care team, the facilitation of empowerment among nurses might decrease moral distress and enhance patient care outcomes at the end of life. No studies have been reported to date that specifically examine the relationship between moral distress and empowerment in nursing thus, in this study, we sought to determine if such a relationship exists.

Moral Distress Related to End-of-Life Care

Several studies have associated levels of moral distress in nurses with the delivery of end-of-life care to patients. In most of the studies reviewed, the most common phenomenon related to end-of-life care that is causing moral distress in critical care nurses is the delivery of futile care. The delivery of futile care at the end-of-life was first examined by Wilkinson, who

Moral distress occurs when nurses are unable to do what they believe to be ethically correct.
built on the work of Jameton. Multiple studies have shown that futile care, where nurses perceived that the patient would not benefit from care, caused the most significant levels of moral distress in nurses.

**Theories of Psychological Empowerment**

Bandura theorized that degrees of empowerment are perceived as one’s sense of self-efficacy is facilitated. Self-efficacy occurs when one’s sense of self-determination is strengthened or one’s sense of powerlessness is weakened. Furthermore, the strength of one’s perceived empowerment determines how obstacles are viewed and the degree to which one overcomes the obstacles.

Conger and Kanungo took self-efficacy a step further by reiterating that true empowerment occurs when convictions of one’s own effectiveness are successfully executed and not merely hoped for. Thomas and Velthouse further postulated empowerment as multifaceted, encompassing 4 cognitions: (1) meaning, the value one attaches to one’s standards, (2) competence, the belief that one is able to carry out one’s beliefs in action, (3) self-determination, the sense that one has control over one’s autonomy, and (4) impact, the degree to which one perceives one’s work as having influence.

**Conceptual Framework**

Although critical care nurses may perceive themselves as having some degree of empowerment with respect to decision making related to end-of-life care, they see themselves as often unable to contribute significantly to decisions they believe to be correct. This “gap” between nurses having empirical knowledge and not being able to apply that knowledge effectively was the impetus for this study intended to explore the association between moral distress intensity, moral distress frequency, psychological empowerment, and select demographics of critical care nurses (see Figure).

**Methods**

**Sample**

A cross-sectional descriptive survey design was used to study a target population of critical care nurses caring for adults at the end of life. A sample of 277 critical care nurses who were on AACN’s e-mail newsletter list were recruited for this study. Inclusion criteria were as follows: (1) must be a critical care staff nurse and (2) must have had experience with caring for dying adults in the critical care setting before completing the survey tools. A brief paragraph describing the study was placed in the AACN newsletter for 4 consecutive weeks. If subscribers were interested in participating, they used a link that led them to the online survey, which started with a cover letter explaining the details of the study further.

**Data Collection (Instruments and Procedure)**

Two valid and reliable survey instruments were used in this study, the 32-item Moral Distress Scale (MDS) and the 16-item Psychological Empowerment Instrument (PEI) in addition to the demographic data survey (see Figure). The MDS-32 has been tested for content validity twice. All items were considered relevant in both testings. Test-retest reliability of the MDS-32 was 0.86 (P < .01). The high reliability may reflect redundancy of some items. The Cronbach alpha was 0.93 (P < .01), demonstrating high reliability. The MDS was later expanded to 38 items. These additional items were unrelated to end-of-life care, so the original 32-item MDS was used.

The MDS measures moral distress intensity, the level at which the nurse experiences painful feelings related to a given situation (none to great extent), and moral distress frequency, how often the nurse experiences the painful feeling associated with the distressful situation (never to very frequently) on a Likert scale from 1 to 7. The MDS uses 3 factors or subscales to measure moral distress: (1) individual responsibility (refers to the nurse participating in care not agreed with or ignoring actions one should take—20 items), (2) not in patient’s best interest (refers to participating...
Most participants reported having had end-of-life care education within the past year.

in care that the nurse considers inappropriate because of futility for the patient—7 items), and (3) deception (refers to the nurse not addressing issues honestly, related to impending death of a patient—3 items). Data from 2 items (12 and 13) on the MDS-32 pertain to children. These 2 items were omitted from the tables presented here because of the study’s focus on the care of adults; however, all 32 items were administered in the survey given to participants.

The PEI is highly reliable and valid,22,24 with reported reliability coefficients ranging from 0.62 to 0.74. The PEI used 4 domains or subscales, previously defined, to measure psychological empowerment: (1) meaning, (2) competence, (3) self-determination, and (4) impact. Each domain addressed 4 items (see Figure) measuring empowerment. Items were scored as follows: 7 = very strongly agree, 6 = strongly agree, 5 = agree, 4 = neutral, 3 = disagree, 2 = strongly disagree, 1 = very strongly disagree.

Quantitative data were collected from October 28, 2010 to November 25, 2010. From the approximately 80,000 e-mailed newsletters, 277 recipients returned the survey. The return rate was approximately 0.35%. Participants were excluded from analyses when they left 25% or more responses blank on any given measure. For example, if a participant left 4 out of 10 responses blank on the MDS, they were left out of analyses comparing moral distress scores with other scale scores. They were included, however, in the descriptive statistics for other measures that were sufficiently completed (<25% missing).

Approval by the institutional review board of the University of San Diego for the protection of human subjects was obtained for this study. The institutional review board determined that written informed consent was not required. A cover letter approved by the institutional review board was posted on the AACN Web site, informing readers about the follow-up.

Results

The following demographics were found within the sample: The participants had a mean age of 46.9 years (SD 10.4). The mean number of years of experience working as a critical care nurse was reported as 17.45 (SD 11). Most participants (n = 234, 84.5%) were working full-time in critical care. The percentage of participants employed part-time was 11.6% (n = 32). Only 1 participant was working per diem. More than half of the nurses (54.6%) reported being active participants in end-of-life patient care conferences. Most of the responding nurses had a bachelor of science degree in nursing (47.1%); 29.2% of the participants had an associate degree in nursing; 19.7% of the nurses had a master of science degree in nursing, and 3.3% of the participating nurses were doctorally prepared. Most of the participants (55.2%) had specialty certification by the AACN, and most participants (54.6%) also reported having had end-of-life care education within the past year. A large majority of participating nurses (86%) reported being members of the AACN. Only 5.8% of the participants (n = 16) reported participation in the critical care training provided by the End-of-Life Nursing Education Consortium (ELNEC).

Moral Distress Intensity and Moral Distress Frequency

Moral distress intensity and moral distress frequency scores ranging from 0 to 2.33 were considered low, 2.34 to 4.66 moderate, and 4.67 to 7.00 high. Scores for moral distress scale subscales and total scores were calculated separately for both intensity and frequency (Table 1).

Mean scores for items on the moral distress intensity scale ranged from 4.39 to 6.05, with an overall mean total score of 5.34 (SD 1.32). The 3 highest-scoring items for moral distress intensity were “assisting [physician] who in my opinion is providing incompetent care” (mean 6.05), “work in a situation when the number of staff is too low and care is inadequate” (mean, 5.97), and “continue
<table>
<thead>
<tr>
<th>Subscale</th>
<th>Item</th>
<th>Mean (SD)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Intensity</td>
</tr>
<tr>
<td>Not in patient’s best interest</td>
<td>1. Follow family’s wishes for patient care I don’t agree with</td>
<td>4.81 (1.52)</td>
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<td></td>
<td>2. Follow family’s wishes to continue life support when not in patient’s best interest</td>
<td>5.47 (1.46)</td>
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<td>3. Follow physician’s orders for unnecessary tests</td>
<td>5.22 (1.53)</td>
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<td></td>
<td>5. Initiate life-saving actions when I think it prolongs death</td>
<td>5.72 (1.46)</td>
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<td></td>
<td>15. Carry out physician’s orders for unnecessary tests and treatments on terminally ill patients</td>
<td>4.39 (2.18)</td>
</tr>
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<td></td>
<td>22. Prepare a terminally ill elderly patient receiving mechanical ventilation for surgery to have a mass removed</td>
<td>5.09 (1.91)</td>
</tr>
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<td></td>
<td>23. Prepare an elderly severely demented patient who is a no code for placement of a gastrostomy tube</td>
<td>5.24 (1.87)</td>
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<tr>
<td></td>
<td><strong>Not in patient’s best interest subscale score</strong></td>
<td><strong>5.13 (1.25)</strong></td>
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<tr>
<td>Individual responsibility</td>
<td>4. Assist physician who performs test or treatment without patient’s consent</td>
<td>5.27 (2.08)</td>
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<td></td>
<td>6. Ignore situations of suspected abuse of patient by caregivers</td>
<td>5.51 (2.16)</td>
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<td></td>
<td>7. Ignore situations of inadequate consent from patient</td>
<td>5.42 (1.76)</td>
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<td></td>
<td>8. Perform procedure when the patient is not adequately informed</td>
<td>5.36 (1.71)</td>
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<td></td>
<td>9. Carry out work assignment in which I do not feel professionally competent</td>
<td>5.27 (1.95)</td>
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<td></td>
<td>10. Avoid taking action when a nurse colleague has made a medication error</td>
<td>4.89 (1.84)</td>
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<tr>
<td></td>
<td>11. Let medical students perform painful procedures on patients solely to increase their skill</td>
<td>5.40 (2.09)</td>
</tr>
<tr>
<td></td>
<td>14. Assist physicians practicing procedures on a patient after cardiopulmonary resuscitation has been unsuccessful</td>
<td>5.09 (2.35)</td>
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<td></td>
<td>16. Work with “unsafe” levels of nurse staffing</td>
<td>5.82 (1.56)</td>
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<td></td>
<td>17. Carry out order to discontinue treatment because patient can no longer pay</td>
<td>5.36 (2.39)</td>
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<tr>
<td></td>
<td>18. Continue to care for a hopelessly injured patient receiving mechanical ventilation when no one will discontinue the ventilation</td>
<td>5.88 (1.50)</td>
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<td></td>
<td>19. Observe without intervening when personnel do not respect patient’s dignity</td>
<td>5.67 (1.68)</td>
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<td></td>
<td>20. Follow physician’s order not to tell patient the truth when he/she asks for it</td>
<td>5.83 (1.78)</td>
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<td></td>
<td>21. Assist physician who in my opinion is providing incompetent care</td>
<td>6.05 (1.56)</td>
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<td></td>
<td>24. Discharge patient based on diagnosis-related groups although he has many teaching needs</td>
<td>5.15 (2.04)</td>
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<td></td>
<td>25. Provide better care for those who can afford to pay</td>
<td>5.20 (2.23)</td>
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<td></td>
<td>26. Follow the family’s request not to discuss dying with a dying patient who asks about dying</td>
<td>5.79 (1.74)</td>
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<td></td>
<td>27. Follow physician’s request not to discuss death with a dying patient who asks about dying</td>
<td>5.76 (1.86)</td>
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<td></td>
<td>28. Work in a situation when the number of staff is too low and care is inadequate</td>
<td>5.97 (1.72)</td>
</tr>
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<td></td>
<td>32. Follow physician’s request not to discuss code status with family when patient is incompetent</td>
<td>5.50 (2.03)</td>
</tr>
<tr>
<td></td>
<td><strong>Individual responsibility subscale score</strong></td>
<td><strong>5.50 (1.47)</strong></td>
</tr>
<tr>
<td>Deception</td>
<td>29. Give medications intravenously during a code with no compressions or intubation</td>
<td>4.68 (2.18)</td>
</tr>
<tr>
<td></td>
<td>30. Give only hemodynamic stabilizing medications intravenously during a code with no compression or intubation</td>
<td>4.49 (2.20)</td>
</tr>
<tr>
<td></td>
<td>31. Follow physician’s request not to discuss code status with patient</td>
<td>5.54 (2.05)</td>
</tr>
<tr>
<td></td>
<td><strong>Deception subscale score</strong></td>
<td><strong>4.92 (1.82)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total of all subscales</strong></td>
<td><strong>5.34 (1.32)</strong></td>
</tr>
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</table>
Nurses with higher levels of perceived empowerment will experience moral distress less often.

Psychological Empowerment

The PEI was used to determine levels of empowerment of critical care nurses in the workplace. Data from this instrument were scored in the following manner: individual item mean scores, mean subscale scores, and a mean total score. Similar to moral distress, PEI scores from 0 to 2.33 were considered low, 2.34 to 4.66 moderate, and 4.67 to 7.00 high.

PEI items ranged from moderate (mean 3.88) to high (mean 6.22). The highest scoring PEI item was, “I really care about what I do on my job” (mean 6.22, SD 1.16). The lowest scoring item was, “I have a great deal of control over what happens in my department” (mean 3.88, SD 1.52). PEI subscale scores were all high: meaning (mean 6.06, SD 1.09), competence (mean 5.92, SD 1.02), self-determination (mean 5.03, SD 1.18), and impact (mean 4.22, SD 1.47). Overall, the total PEI mean score indicated a high degree of psychological empowerment (mean 5.31, SD 1.00).

Correlational Analysis of Moral Distress and Demographics

Weak but significant positive correlations were found between the moral distress item “not in patient’s best interest” and age ($r = 0.179$, $P = .01$) and ELNEC critical care training ($r = 0.185$, $P = .008$). Likewise weak but significant positive correlations were found between ELNEC training and the items “not in patient’s best interest” ($r = 0.194$, $P = .006$) and total score for moral distress frequency ($r = 0.165$, $P = .02$). A weak but significant negative correlation was found between active collaboration in end-of-life patient care conferences and items related to deception ($r = -0.191$, $P = .007$).

Correlational Analysis of Empowerment and Demographics

Several significant positive correlations were found between psychological empowerment and the nurses’ demographics (Table 2). Significant and moderate correlations were found between empowerment related to competence and years of critical care experience ($r = 0.255$, $P = .001$). Other moderate and significant correlations were found between empowerment related to self-determination and collaboration in end-of-life care conferences ($r = 0.217$, $P = .001$) and end-of-life care education in the past year ($r = 0.209$, $P = .001$). In addition, a significantly positive moderate correlation was found between empowerment related to impact and collaboration in end-of-life care conferences ($r = 0.253$, $P = .001$).

All empowerment subscale scores (meaning, competence, self-determination, and impact) and total empowerment scores significantly correlated positively with end-of-life care education in the past year ($r = 0.221$, $P = .001$). No correlations were found between empowerment and AACN membership or CCRN certification; therefore, these data were omitted from Table 2.

Moral Distress Intensity/Frequency and Psychological Empowerment

Relationships between psychological empowerment and moral distress intensity and frequency were computed by using a Pearson product coefficient. A moderate and significant negative correlation was found between moral distress frequency related to individual responsibility and empowerment related to impact ($r = -0.249$, $P = .001$) and moral distress frequency total scores and empowerment related to impact ($r = -0.229$, $P = .002$). Total psychological empowerment scores negatively correlated with moral distress frequency (individual responsibility subscale; $r = -0.213$, $P = .004$; see Table 2).
Multiple regression analysis was used to test if any demographic variables combined with total PEI scores were predictors of the frequency of experiencing moral distress. The results of the regression analysis indicated that 2 predictors explained 8.40% of the variance ($R^2 = 0.289, F_{2,171} = 7.801, P < .01$). It was found that nurses’ having had ELNEC critical care training was a significant predictor of moral distress frequency ($\beta = .222, P < .01$). For every 1-point increase on the PEI, moral distress frequency scores decreased by 0.222 points ($P < .01$). The analysis indicated that it can be predicted that ELNEC critical care trained nurses will experience moral distress more often, and nurses with higher levels of perceived empowerment will experience moral distress less often.

**Discussion**

Moral distress intensity was high among critical care nurses, whereas moral distress frequency was moderate to low. These findings are consistent with the results of Corley et al., in that the frequency was...
lower than the intensity, implying that the morally distressing events that the nurses experienced were not occurring often. Moral distress intensity was higher in our study than in the study by Corley et al. In our study, nurses reported the highest level of moral distress intensity in the individual responsibility domain, with the second highest level of moral distress intensity related to the items not in patient’s best interest, although the difference in mean scores was negligible (0.37). In previous studies, researchers reported that the highest moral distress intensity resulted from items not in the patient’s best interest (futile care).

As nurses’ age increased, so did moral distress intensity. Nurses participating in end-of-life patient care conferences reported less moral distress frequency in being able to address issues related to the impending death of a patient honestly. Overall, the more empowered nurses perceived themselves, the less often they experienced moral distress.

Nurses who reported having ELNEC critical care training experienced significantly greater levels of moral distress intensity and frequency in items related to “not in patient’s best interest” (participating in care that the nurse considered inappropriate because of futility for the patient). This may be explained by nurses, having gained more information regarding the correct actions to take in situations of delivering futile care to dying patients, felt higher levels of moral distress because they were not able to carry out their desired actions contributing to optimal patient care. Also, few participants (16 out of the total number) reported ELNEC critical care training. Several positive significant correlations were found between psychological empowerment and the demographics. In our study, nurses who reported participating in end-of-life care education in the past year reported higher levels of psychological empowerment in all domains. This is consistent with Corbally et al., who conducted a qualitative study examining empowerment in 93 nurses and midwives. Education for practice was an antecedent to empowerment.

We found that as age and years of critical care experience increased, nurses reported higher levels of empowerment related to competency. Nurses who worked more hours per week were more empowered related to impact. This finding is consistent with results reported by Knol and van Linge: in their cross-sectional study of nurses using the PEI, they found that registered nurses who worked more hours per week perceived themselves as more psychologically empowered.

We found that nurses who reported active collaboration in end-of-life patient care conferences had higher levels of empowerment related to self-determination and impact. This finding is consistent with results of a mixed-method study using the PEI and interviews done by Williamson examining home health nurses’ perception of psychological empowerment. PEI scores were high in this study, and interviews of participants identified collaboration as one of the most important facets of empowerment.

Nurses who scored higher in the following: (1) meaning (attaching greater value to their work), (2) self-determination (feeling higher levels of autonomy), and (3) impact (having greater influence at work) experienced higher levels of moral distress intensity related to deception (situations where they felt unable to address issues related to the impending death of a patient honestly). Nurses who felt more empowered may have been more distressed about not being able to actualize what they perceived as the correct actions.

However, nurses who scored higher in empowerment related to self-determination experienced moral distress less frequently when participating in situations requiring them to ignore taking actions they felt they should take (individual responsibility). Nurses who perceived themselves as more empowered related to their impact experienced moral distress less often when dealing with situations involving the delivery of aggressive care in cases of patient futility (not in patient’s best interest).

Limitations

In this study, we did not differentiate between geographical areas or types of facilities in which nurses practiced, nor did we take into consideration nurses’ sex or culture. The sample was taken from subscribers to the AACN newsletter. This population of nurses may be more apt to feeling empowered and/or feeling greater or less levels of moral distress. The nature of convenience sampling versus random sampling may have limited the study’s findings in terms of predictability and generalizability. The relatively low response rate was perhaps due to the large volume of surveys that AACN newsletter subscribers are asked to complete.

Conclusion

In this study, we sought to examine the relationship between moral distress and psychological empowerment in critical care nurses related to end-of-life care. The results revealed a significant positive relationship between moral distress intensity and psychological empowerment in the surveyed population of nurses; however, nurses who perceived themselves as more empowered experienced moral distress less frequently. Another pertinent finding
was that nurses who participated in end-of-life patient care conferences experienced less moral distress frequency in situations related to honestly addressing issues dealing with patients facing impending death.

Nurses more advanced in age and nurses who participated in ELNEC training reported more moral distress intensity related to care that nurses considered futile for the patient. This study indicated that the following nursing demographics were significantly related to higher levels of psychological empowerment: age, years of critical care experience, work status, collaboration in end-of-life patient care conferences, level of education, ELNEC training, and end-of-life care education in the past year.

The data supported the relevance of an investigation seeking to correlate moral distress and empowerment related to select demographics as stipulated in the conceptual framework. No significant correlations were found related to AACN certification or AACN membership. Future studies are recommended to address additional demographics such as sex, critical care specialty area, and type of institution where practicing.

Despite the numerous significant positive relationships between the demographics and psychological empowerment, participants did not experience decreased moral distress intensity in relationship to increased degrees of psychological empowerment. However, the data supported that critical care nurses who perceive themselves as more psychologically empowered experience moral distress less frequently.

This study offers several insights into the continuation of a research agenda concerning the potential for decreasing moral distress in critical care nurses related to end-of-life care. Further research examining empowerment as it relates to moral distress is needed to find methods that may decrease moral distress in critical care nurses. Further exploration of how bioethical principles can be more effectively incorporated into nursing education so that nurses may be better equipped to articulate bioethical principles related to end-of-life care as they apply them to patient care situations in multidisciplinary patient care conference settings is recommended. The results of this study provide relevant data that may increase insight into future interventional studies, potentially aiding in the reduction of moral distress in critical care nurses related to end-of-life care.

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None reported.

REFERENCES

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