Spring 4-24-2020

Moral Distress: Unaddressed Challenges for The "Most Honest and Ethical Profession"

Kelly Straight
kastraight@usfca.edu

Moral Distress: Unaddressed Challenges for The "Most Honest and Ethical Profession"

Kelly A. Straight

Unaddressed Challenges for The "Most Honest and Ethical Profession"

Abstract

Nurses and nurse practitioners (NPs) face greater responsibility to address the ethical challenges that present during the course of patient care, due to advances in medical technology and pharmaceutical innovation, and despite widening disparities within the U.S. healthcare system. These ethical questions, which arise during the course of routine patient care, are increasing in both number and complexity in nearly every patient care setting. Unresolved and/or ongoing ethical questions and conflicts encountered in patient care pose further issues such as the development of moral distress. The literature demonstrates that moral distress contributes to dissatisfaction, disengagement, and burnout which negatively affects patient safety, quality of care, labor costs, and sometimes the permanent loss of NPs who change careers due to this stress. The purpose of this article is to discuss the ethical problems encountered by NPs who work in a primary care setting, the distress that results from unresolved ethical dilemmas and conflicts as well possible solutions to mitigate the development of moral distress. Addressing this issue is vital to the health of the nursing profession: for 18 consecutive years, nursing has been voted the most honest and ethical profession by 85% of Americans in an annual poll conducted by Gallup (Reinhart, 2020). To maintain that trust, nurses and NPs must be trained in and comfortable with addressing moral distress in practice.

Introduction

Nurses and nurse practitioners (NPs) face greater responsibility to address the ethical challenges that present during the course of patient care, due to advances in medical technology and pharmaceutical innovation, and despite widening disparities within the U.S. healthcare system. These ethical questions, which arise during the course of routine patient care, are

increasing in both number and complexity in nearly every patient care setting. Ethics imbues

every aspect of nursing; it was codified as part of the profession since the American Nurses

Association (ANA) first published the *Code of Ethics for Nurses with Interpretive Statements*

(CoE) in 1950. Even with codified ethical standards, however, unresolved and/or ongoing ethical

questions and dilemmas pose further issues such as the development of moral distress. The

literature demonstrates that moral distress contributes to dissatisfaction, disengagement, and

burnout which negatively affects patient safety, quality of care, labor costs, and sometimes the

permanent loss of NPs who change careers due to this stress (DeMilt, Fitzpatrick & McNulty,

2011). Glassdoor (www.glassdoor.com) reports that the average nation-wide salary for NPs runs

between $105,000 and $138,000 with an average of $117,000 (2019). Turnover costs escalate

after benefits and sign-on bonuses are factored in; new vacancies also increase costs associated

with longer wait times for patients to see providers.

This article will discuss the ethical problems encountered by NPs who work in a primary

care setting, the distress that results from unresolved ethical dilemmas and conflicts and possible

solutions to mitigate the development of moral distress. While the majority of the literature

focuses on ethical issues faced by acute care practitioners, more research must address the nature

and resolution of ethical issues faced by primary care NPs. The urgency of this issue cannot be

overstated given the projected primary care physician shortage of more than 23,000 by 2025 with

only eight percent of graduate medical trainees entered primary care residencies in 2018 yet 87%

of new NPs in 2018 received their graduate training in primary care programs (AANP, 2019)

helping to fill an acute shortage of trained providers (Pohl, Thomas, Bigley & Kopanos, 2018).

While "…it may be impossible to practice nursing without encountering some degree of ethical

conflict" (Radzvin, 2011, p. 43) and "…it is doubtful that moral distress can ever be eradicated

from healthcare settings" (Epstein & Hamric, 2009, p. 11), nurses and NPs must receive ongoing support and interventions to help mitigate the conflicts and resulting moral distress experienced in practice. The consequences of doing nothing are potentially disastrous: moral distress can lead to disengagement and burnout, which can lead to poor coping mechanisms including alcohol and substance use, development of somatic symptoms and vulnerability to illnesses. Additional consequences include turnover costs, provider shortages, and patient outcomes compromised by delays in receiving care.

Defining Moral Distress

In nursing, as in all healthcare professions, moral distress occurs when "we know the right thing to do while being in a situation in which it is nearly impossible to do it" (Jameton, 1984, 2017). In 1984, Andrew Jameton conceptualized the definition of moral distress as the following: "(a) the psychological distress of (b) being in a situation in which one is constrained from acting (c) on what one knows to be right" (p. 6). Although this definition has developed more nuance over the years, his core concept remains. Jameton also notes that the published research on moral distress has increased dramatically in the last ten years and has spread to other disciplines outside of nursing (2017). Included in this body of literature, are many attempts to both define and refine not only the concept of moral distress, but associated terminology such as "moral uncertainty," "moral residue," and "moral injury." N.B.: "moral injury" is typically used in military trauma literature but was co-opted by physicians in 2018 as a replacement for "moral distress." Per Rushton, although this is an under-studied phenomenon, "what both of these terms signify…is a sense of suffering that clinicians are experiencing in their roles now, in ways that they haven't in the past." (Bailey, 2020, para. 7). The parsing of the terminology is outside of the scope of this article for this purpose, Jameton's core concept will be utilized throughout.

Description of the Conceptual Framework

     In 2007, Carolyn Laabs developed and published a theoretical framework for addressing the reconciliation of moral integrity among nurse practitioners (NPs) who work in the primary care setting. Since 2005, Laabs has published extensively on ethical dilemmas and the resulting moral distress among NPs in primary care in an effort to identify the types of ethical problems and level of distress experienced within this population. Laabs' Grounded Theory of Maintaining Moral Integrity in the Face of Moral Conflict describes the process by which NPs in primary care process and manage the ethical concerns encountered in their work as well as the consequences of moral problems (2007). According to Laabs' theory, the process includes four phases developed within the context of the work environment: relationship to the patient, level of experience, knowledge, and values. The phases include presenting a situational conflict; drawing a theoretical line the NP would or would not cross within the situation; attempting to meet the needs of the patient while not crossing that theoretical line; and, finally, evaluating each NPs own sense of integrity as a result of the action taken in the given scenario. Laabs notes that NPs who are able to reconcile their sense of integrity do not then experience any further distress but NPs who are unable to do so will experience distress for an indeterminate period of time.

     Laabs' theory of maintaining moral integrity provides an excellent framework for examining research on ethical issues and moral distress among NPs. Laabs' concept around the development of moral distress based on the NP's ability to reconcile an ethical situation without compromising her personal and professional integrity applies to a common source for moral distress such as a patient's inability to pay for care (2005). If the NP is able to resolve that conflict without violating her sense of integrity, she would be less likely to experience moral distress.

The same can be said for Radzvin's research on Certified Registered Nurse Anesthetists (CRNAs) who not only report feelings of moral distress over being asked to provide care they feel is futile, but also moral distress caused by working with staff perceived to be incompetent and organizational policies with which they do not agree (2011). This phenomenon is also seen in the study conducted by Ulrich et al. among NPs and PAs within a managed care organization (MCO) (2006). In all these studies, nurses who were able to reconcile an ethical dilemma without compromising their own sense of moral integrity were less likely to suffer from lingering feelings of moral distress.

Each NP will have a different sense of personal and professional integrity that impacts the development of moral distress. As Laabs points out, the ethical issues encountered in primary care are often quite different from those encountered in other specialties such as the emergency department (ED), oncology, or pain management. Therefore, the degree of moral distress and level of burnout may be different as well (2005). Nevertheless, this framework provides the theoretical underpinnings for further study of the root cause of moral distress for NPs in primary care because sense of integrity and other variables differ across individuals.

Review of the Evidence

Determining Ethical Issues and Moral Distress in Primary Care

Laabs (2005), conducted a preliminary investigation of primary care NPs designed to: identify ethical issues encountered in primary care; analyze the moral problems that resulted as a consequence of those ethical issues; and determine when NPs were experiencing moral distress. While only 33 percent of respondents reported occasionally or commonly experiencing the listed ethical issues - such as feeling "constrained to treat

patients who are unable to make payment"; "pressure to see [too many] patients"; and "clinical decisions made by other providers" - other problems included conflict between ensuring patient autonomy while providing beneficent care. Overall findings indicate that the level of distress and frequency of ethical issues encountered by primary care NPs is comparable to those found in acute care nurses.

Within a managed care organization (MCO), 55% reported daily to weekly problems with MCO interfering in the plan of care and 47% reported being asked by a patient to exaggerate their condition to ensure coverage for care (Ulrich et al., 2006) Almost all respondents agreed that it was unethical to "game the system," with the majority reporting they would likely intervene on behalf of the patient to cover treatment by going through an appeals process, for example however, 29% of respondents simultaneously acknowledged that sometimes advanced practice providers (APPs) have to "bend the rules" to help patients get the care recommended by their providers. The researchers found that providers who found it acceptable to "bend the rules" did so because they felt it was their responsibility to do so as advocates for their patients, but such perceived responsibilities were associated with higher ethical conflict scores.

Moral Distress Among CRNAs

Radzvin (2011) found that Certified Registered Nurse Anesthetists (CRNAs) age 24 – 30 reported more moral distress than older practitioners and noted that, while not statistically significant, CRNAs with more years of experience reported decreasing moral distress with longer years in practice. This may be due to younger CRNAs lacking experience or comfort level in dealing with ethical situations as they present during patient care. Conversely, it could be that older and more experienced CRNAs are experiencing the "moral residue crescendo" resulting in

numbed moral sensitivities as studied by Epstein and Hamric (2009). Doctor of Nursing Practice

(DNP)-prepared CRNAs were found to have the highest levels of moral distress within this study

(Radzvin, 2011). In a more recent study conducted by Wands, CRNAs who perceived

themselves to have a high skill level at addressing ethical concerns were less likely to report

feelings of moral distress, irrespective of whether the CRNA practiced independently, had a

supervisory relationship with a physician, or was under full direction from a physician (2018).

Level of Practice Authority and Moral Distress

Currently, NPs in fewer than half of the states in the U.S. have full practice authority

(FPA). Non-FPA states require restricted or reduced authority via forced contracts with

physicians or state medical boards. Per the AANP, "Full Practice Authority is the authorization

of nurse practitioners (NPs) to evaluate patients, diagnose, order and interpret diagnostic tests

and initiate and manage treatments—including prescribe medications—under the exclusive

licensure authority of the state board of nursing" (2018). Mandatory physician oversight in non-

FPA states has been linked to geographic health care disparities, increased burden of chronic

disease, and higher costs of care (AANP, 2018; Spetz, 2019). Barriers to FPA are largely the

result of concerted efforts by physician organizations such as the American Medical Association

and Physicians for Patient Protections which, citing safety concerns, are adamantly opposed to

FPA (Cheney, 2019). This opposition comes despite serious physician shortages in primary care,

especially in under-served areas, and similar quality and safety outcomes across the board for

physicians, NPs, and PAs (Spetz, 2019).

The difficulty in determining whether there is a correlation between moral distress and

NP scope of practice or practice authority lies in whether NPs within a given sample consider

moral distress as part of stress and burnout when they respond to study questionnaires (Laabs,

2005 & 2007). Furthermore, survey data obtained via convenience sampling may not be reflective of NPs as a whole and can be complicated by data from NPs in a state with full practice authority vs NPs from other states with a more limited scope of practice. Although a cross-sectional study of job satisfaction and intent to leave among a national NP sample demonstrated that the most common reason NPs intend to leave the profession is related to retirement (De Milt, Fitzpatrick, & McNulty, 2011), the most common reasons behind intent to leave their _current_ positions included "little control over practice" and "limited opportunities for internal career advancement" (p. 47). Whether future studies of NPs can demonstrate a correlation between moral distress and practice independence remains to be seen.

Moral Distress in the Emergency Department

Trautmann, et al. (2015) examined NPs in the ED (to which, incidentally, many patients go seeking primary care) and the relationship between both intent to leave the profession and level of practice authority. The authors found no statistical significance between independent practice as a predictor of moral distress; however, NP gender neared statistical significance with more women than men reporting moral distress. Interestingly, the authors found the most likely causes of moral distress were specific to poor communication between staff and patients and perceived (in)competence of co-workers. This differs from other studies which demonstrate patient non-adherence, insurance difficulties, and productivity are causative factors for moral distress among NPs (Poghosyan, Liu, Shang & D'Aunno, 2017). Additionally, practice independence was determined not to be a causative factor for moral distress as anticipated by the authors based on their literature review.

Confounding Factor: the Role of Religion/Spirituality in Ethical Beliefs and Moral Distress

Within the various healthcare disciplines, there are healthcare workers who identify

themselves as being religious or spiritual and, undoubtedly, some of them feel that their religion

informs their biomedical decision making. Karen Armstrong, former Catholic nun and premiere

scholar on world religions often discusses the commonalities between religions as well as how

religion has been used by various followers throughout history. In a 2018 interview, she notes "I

found that every single religious tradition has formulated the [that] Golden Rule - and said that it

is <u>that</u> - and not a particular doctrine, that is the fundamental teaching of their tradition"

(Badruddin, 2018). Furthermore, she posits that the Golden Rule, or compassion, is the root

ethical belief in all religions despite a long history of people using religious doctrine to justify

conflict and violence throughout history.

   In a 2017 Pew Research Center study, 54% of Americans consider themselves "religious"

while 75% identify themselves "spiritual" (Lipka & Gecewicz); it stands to reason that

religion/spirituality would impact ethical beliefs of healthcare workers. The extent of the effect,

however, varies by study. In a study of 1,100 nurses in Idaho, far more respondents said their

work/life experiences (34%) and religion influenced their ethical beliefs (29.4%) above even the

COE (9%) (Davis, Schrader & Belcheir, 2012). This study also demonstrated that overall, 75%

of respondents felt that a patient's right to healthcare superseded the nurse's right to

conscientious objection, although the group influenced most by religion were less likely to agree

that a patient's right superseded conscientious objection unless in a life or death situation. The

authors postulate that because conscientious objection has been associated with unresolved moral

distress in other studies, this phenomenon may explain why the religious belief group reported

the highest percentage of moral distress.

   In a small study of physicians and medical residents, Prairie, Wrye & Murfree found that

those who were inclined to refuse treatment to LGBT+ patients in a hypothetical situation cited

religion as their reasoning and did so without any prompting about religion/spirituality. The remaining participants were against the right to refuse treatment to this patient population and cited the Hippocratic Oath or other ethical reasons. The authors note that while most respondents in this study who felt it was unacceptable to refuse care to LGBT+ patients were medical residents who were generally younger than the practicing physicians, this correlation has not been shown in other research. Not discussed in the article but pertinent to the topic of moral distress is the ethical quandary that may be experienced by a medical resident who wishes to provide care to a LGBT+ patient but who works under an attending physician who does not want to provide care to that patient population. While conscientious objection may allow a physician to refuse to participate in physician-aid-in-dying, for example, it does not permit refusal to treat LGBT+ patients simply because a physician does not agree with how a patient lives her/his life (Hull, 2019). In a situation where a medical resident who feels constrained to do what is right (providing care to a LGBT+ patient) because the attending physician refuses to treat a LGBT+ patient, may result in moral distress for the resident.

Finally, two studies of military healthcare personnel demonstrated mixed results regarding religion/spirituality. In a 2016 study of Naval physicians who received varying degrees of pre-deployment ethics training, participants denied that religion contributed either positively or negatively in situations of ethical compromise or frequency of ethical problems during deployment (Gaidry & Hoehner). The authors also found that participants relied more upon medical ethics than military ethics and suggest that status quo military-only pre-deployment ethics education did little to encompass the complexity of providing medical care in the military setting during deployment. This put Naval physicians at risk for developing moral injury, which can result in depression and risk of suicide (2016).

Conversely, a study of military flight nurses deployed to Iraq and Afghanistan showed that spirituality could be either helpful or harmful during deployment with some nurses reporting that their spirituality in combination with the work of flight, or "en route" nursing, led to development of moral injury and moral distress (Simmons, et al., 2018). The ethical dilemmas common to military healthcare especially during modern times of war, where neither treatment option is deemed "right" or "good," left several study participants feeling guilty for not having "done enough" and "needed to ask for forgiveness from God" (2018, p. 65). Most commonly, these situations involved children and some participants described difficulty reintegrating with society upon returning home, noting that the cry of a child was deeply upsetting. While most of the participants in the study reported that their spirituality provided comfort and strength during the difficulties of deployment, it is clear that the impact of religion/spirituality on ethics and moral distress requires further study.

How Ethics Education is Provided in Healthcare Training Programs

Ethics education in undergraduate nursing programs is lacking "best practice" subject matter outside of what is delineated in the Code of Ethics (Grace & Milliken, 2016). Historically, medical school ethics education has fared no better according to a 2004 study of U.S. and Canadian medical schools (Soleymani-Lehmann, Kasoff, Koch, & Federman). In Carrese et al's Romanell Report on The Essential Role of Medical Ethics Education in Achieving Professionalism (2015), the authors suggest there remains a continued lack of consensus around the essential knowledge of ethics and ethics competencies for medical students as well as best practices for assessment of those skills. Furthermore, physician residency programs vary in how the individual programs are conducted within the various facilities which includes access to ethics education and ethics resources. It is clear there is room for improvement in how ethics

education is provided and a need for consensus on required materials across healthcare disciplines. Rozmus, Carlin, Polczynski, Spike, and Buday (2015) developed an innovative method to provide ethics education involving the schools of medicine, nursing, dentistry, public health, and biomedical informatics; however the method lacked truly interprofessional engagement, because it was conducted individually within each health professions school rather than incorporating interdisciplinary participation.

In a review of Lin et al's 2013 study of interprofessional problem-based learning of ethics between Taiwanese nursing and medical students, Kurtz and Starbird discuss several challenges inherent to both interprofessional education in general and interprofessional ethics-specific education (2016). While in Lin et al's study, the interprofessional learning group demonstrated higher self-evaluation scores on communication and collaboration than did the medical student only group, outcome measures were limited to self-report and are not necessarily indicative of future behaviors and attitudes. Furthermore, in Taiwan, both medical and nursing education occurs at the undergraduate level, so there is less variability in age and experience as seen in the United States. Lastly, learning and teaching guidelines for students and faculty must be in place to ensure successful implementation of interprofessional ethics education (2016).

More work must be done to research best practices for provision of ethics education, particularly interprofessional educational opportunities such as shared didactics, case study review, problem-based learning, and/or experiential learning opportunities within healthcare training programs - even if that means collaboration between disparate colleges and universities. In a study of ethics confidence and quality of care among NPs and PAs, Ulrich, et al concluded that innovative interdisciplinary education models to provide the complex ethics education required to treat increasingly complex patient populations in primary care (2014).

Furthermore, interprofessional education must include other disciplines outside of just nursing and medicine. It must bring in physical, respiratory, occupational, and speech therapy as well as social work, pharmacy, and dietetics. Without the inclusion of the other healthcare disciplines involved in patient care in an interprofessional education (IPE) program, it is not really *interprofessional* education. IPE ethics education also serves to develop mutual respect for roles and values inherent within the various disciplines on the healthcare team (Ulrich, et al, 2014).

Strategies to Counteract Moral Distress

Development of Moral Resiliency

Moral resiliency is a new and growing field of interest for all healthcare professions, as it has been identified as one of many required skills for mitigating the effects of moral distress. Moral resilience can be defined as "the ability to respond positively to the distress and adversity caused by an ethically complex situation" (Rushton, 2017, p. S11) and is a means of "shifting the narrative from one of distress and depletion to one of solutions and possibilities…" (p. S13). Strategies to improve moral resilience include Rushton's Mindful Ethical Practice and Resilience Academy (MEPRA) workshops which strive to help nurses in the acute care setting (2017). The recent creation of a Resiliency Center for the employees at the University of Utah Health is intended to confront the ever-present "traumatic and stressful events" experienced by physicians, physician-trainees, and other health care workers (HCWs) (Morrow, Call, Marcus, and Locke, 2018, p. 293). There is a dearth of published literature on moral resilience best practices, but the authors anticipate that promotion of health and wellness via the Resiliency Center will demonstrate improvements in satisfaction and engagement survey results (Morrow et al., 2018). In the absence of a dedicated center for resiliency, there remains a lack of formal programs for

providers within the workplace to promote resilience. The creation of a Chief Wellness Officer

(CWO) within the C-suite is a very recent phenomenon and thus far is limited to large hospital

systems. While it is a necessary step in the right direction (Kishore et al, 2018), there remains a

gap for out-patient clinics and the providers who work in them.

Identifying Commonalities in the Definition of, and Development of, Moral Resiliency

        Holtz, Heinze, & Rushton (2017) conducted a qualitative descriptive study to analyze

interprofessional healthcare workers (HCWs) self-reported definitions of "moral resiliency."

Both licensed HCWs and non-clinician HCWs (including chaplains) selected from various

educational programs around the U.S. were asked to participate by responding to a single

question about their personal definition of moral resilience. The responses were categorized into

three main themes and three sub-themes: personal integrity, relational integrity, buoyancy, self-

regulation, self-stewardship, and moral efficacy. This analysis contributes to the body of

literature around development of moral resiliency as a means to negate moral distress. The

themes of personal and relational integrity correspond to the framework developed by Laabs

(2007) discussed earlier in this paper.

        A systematic review of resilience of physicians in a primary care setting found variability

between the various definitions of resilience, and the personal characteristics and workplace

environment correlated with resilience (Robertson et al., 2016). Interestingly, of the 13 studies

included, more than half defined resilience in a way that either compared and contrasted

resilience to burnout; the remaining studies defined resilience either as the ability to "bounce

back" from difficult events or a development of positive adaptation skills for dealing with

adversity. It is clear from this review that developing resilience is a multifaceted process that

requires both personal and professional strategies to counteract the adverse effects experienced

by healthcare professionals, especially primary care providers.

Rushton proposes several methods for personal cultivation of moral resilience within healthcare professions, including practicing meditation and mindfulness, which help practitioners care for their mental, physical, and emotional selves; cultivating reflection and insight; developing moral efficacy and self-attunement; and cultivating regular self-care/-stewardship (2018). Developing moral efficacy "…requires knowledge and cognitive capabilities…analysis and behavior or action…" (Rushton, 2018, p. 166) which one acquires from both education and experience. As mentioned earlier in this article, ethics education is being taught in most healthcare training programs. But, with the exception of the behavioral health sciences like social work and psychology, which have required continuing education credits in ethics in nearly every state, there is no nation-wide mandate for the other professions to obtain ethics-specific continuing education. Currently, requirements vary by state, profession, and board certification requirements. Moral distress has negative implications for every healthcare profession and these studies demonstrate the potential of using researched and defined qualities of moral resilience to promote reduction of moral distress for NPs in all settings.

The Promise of DNP-Prepared Nurse Practitioners

Despite the NP Core Competency update in 2017, concerns exist for ethics education in Doctor of Nursing Practice (DNP) programs, including a lack of standards for who teaches the content, what the content should include, and methods for education outcomes (Laabs, 2015). Grace (2018), however, discusses the importance of remembering that "ethical nursing" goes beyond the four basic bioethical principles and provision of care whether in health or illness, to encourage "everyday nursing ethics." DNP programs place a lot of emphasis on leadership development for NPs, and this creates an ideal opportunity to help DNP students develop the

transformational leadership skills best-suited for ethical provision of care, understanding and meeting the goals of the profession, and then working to further the profession – all of which falls under the CoE and the DNP essential domains. The tools to understand and provide ethical care are insufficient without development of transformational leadership skills (Grace, 2018). Finally, there is an urgent need for DNP nurses to fill the faculty vacancies where they can be "ethically skilled" educators for students as well as currently practicing nurses in all areas of healthcare.

Implications for Practice

The literature demonstrates that moral distress contributes to dissatisfaction, disengagement, and burnout which negatively affect patient safety, quality of care, labor costs, and sometimes the permanent loss of NPs due to career changes. Undoubtedly, more than one approach will be necessary; there is no simple solution to addressing moral distress. Ongoing ethics education may be one approach (Laabs, 2005, 2007, 2012). Another may be ongoing interdisciplinary ethics education, with review and discussion of case studies to recalibrate participants' sense of integrity by prompting self-reflection and promoting personal and professional growth (Straight, 2018). Furthermore, ongoing ethics education promotes moral efficacy, which is part of fostering moral resilience (Rushton, 2018). DNP programs can provide the leadership development to enhance students' moral agency and empower development of moral agency in others (Grace, 2018). The identification of themes related to moral resilience can also be used in future research of strategies to mitigate the effects of moral distress (Holtz et al., 2017), in addition to developing a standardized definition of resilience to facilitate development of evidence-based interventions (Robertson et al., 2016). It is clear that multiple strategies are required at the personal, educational and organizational levels to

assist NPs in developing competence with both nursing and biomedical ethics and moral resiliency.

A Call to Action

For 18 consecutive years, nursing has been voted the most honest and ethical profession by 85% of Americans in an annual poll conducted by Gallup (Reinhart, 2020). The trust the public places in nursing above all other healthcare disciplines is both a cause for pride and a reminder of our duty to the patients and communities we serve. Part of maintaining that trust is providing ethical care and addressing moral distress in practice. Alleviation of moral distress is a complicated process but one that NPs and the organizations and facilities that employ them must prioritize to prevent burnout, promote quality of care for patients, and retain knowledgeable and caring NPs in all practice settings.

The author declares that there is no conflict of interest.

References

American Nurses Association. (2015b). *Code of ethics for nurses with interpretive statements.* Silver Spring, MD: Nursesbooks.org Retrieved from www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses /Code-of-Ethics-For-Nurses.html

Badruddin, S. (2018, August 26). An interview with dr karen armstrong: The golden rule and religion. Retrieved from https://the.ismaili/usa/interview-dr-karen-armstrong-golden-rule-and-religion

Bailey, M. (2020, February 5). Beyond burnout: Docs decry 'moral injury' from financial pressures of healthcare. Retrieved from https://www.fiercehealthcare.com/practices/beyond-burnout-docs-decry-moral-injury-from-financial-pressures-healthcare

Carrese, J., Malek, J., Watson, K., Soleymani-Lehmann, L., Green, M., McCullough, L., Geller, G., Braddock, C., & Doukas, D. (2015). The Essential Role of Medical Ethics Education in Achieving Professionalism: The Romanell Report. *Academic Medicine*, 90(6), 744-752. doi: 10.1097/ACM.0000000000000715

Cheney, C. (2019, February 27). Why Physician Assistants and Nurse Practitioners Need Supervision, Say Physician Groups. Retrieved from https://www.healthleadersmedia.com/clinical-care/why-physician-assistants-and-nurse-practitioners-need-supervision-say-physician-groups

Davis, S., Schrader, V., & Belcheir, M. J. (2012). Influencers of ethical beliefs and the impact on moral distress and conscientious objection: *Nursing Ethics*, 19(6) 738–749. doi:10.1177/0969733011423409

De Milt, D. G., Fitzpatrick, J. J., & McNulty, S. R. (2011). Nurse practitioners' job satisfaction

and intent to leave current positions, the nursing profession, and the nurse practitioner role

as a direct care provider. *Journal of the American Academy of Nurse Practitioners, 23*(1),

42-50. doi:10.1111/j.1745-7599.2010.00570.x

Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect.

The Journal of Clinical Ethics, 20(4), 330-342.

Gaidry, A., & Hoehner, P. (2016). Pilot study: The role of predeployment ethics training,

professional ethics, and religious values on naval physicians' ethical decision

making. *Military Medicine*, 181(8), 786-792. doi:10.7205/MILMED-D-15-00104

Grace, P. (2018). Enhancing nurse moral agency: The leadership promise of doctor of nursing

practice preparation. *The Online Journal of Issues in Nursing*, 23(1). Retrieved from:

http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN

/TableofContents/Vol-23-2018/No1-Jan-2018/Enhancing-Nurse-Moral-Agency.html

Holtz, H., Heinze, K., Rushton, C., & Bunting, G. L. (2018). Interprofessionals' definitions of

moral resilience. *Journal Of Clinical Nursing*, 27(3/4), e488-e494. doi:10.1111/jocn.13989

Hull, S. (2019, November 8). Not so conscientious objection: When can doctors refuse to treat?

Retrieved from https://www.statnews.com/2019/11/08/conscientious-objection-doctors-

refuse-treatment/

Jameton A. (1984). *Nursing practice: the ethical issues.* Englewood Cliffs, NJ: Prentice Hall

Jameton, A. (2017). What moral distress in nursing history could suggest about the future of

health care. *AMA Journal of Ethics, 19*(6), 617-628.

doi:10.1001/journalofethics.2017.19.06.mhst1-1706.

Kishore, S., Ripp, J., Shanafelt, T., Melnyk, B., Roger, D., Brigham, T., Busis, N., Charney, D.,

Cipriano, P., Minor, D., Rothman, P., Spisso, J., Kirch, D., Nasca, T., & Dzau, V., (2018, October 26). Making The Case For The Chief Wellness Officer In America's Health Systems: A Call To Action. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20181025.308059/full/ DOI: 10.1377/hblog20181025.308059

Kurtz, M. & Starbird, L. (2016). Interprofessional Clinical Ethics Education: The Promise of Cross-Disciplinary Problem-Based Learning. *AMA Journal of Ethics*, *18*(9), 917-924. doi: 10.1001/journalofethics.2016.18.9.nlit1-1609.

Laabs, C. A. (2005). Moral problems and distress among nurse practitioners in primary care. *Journal of the American Academy of Nurse Practitioners, 17*(2), 76-84. 10.1111/j.1041-2972.2005.00014.x Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-20444438793&doi=10.1111%2fj.1041-2972.2005.00014.x&partnerID=40&md5=41080cd84f57f4c232091f4412afa351

Laabs, C. A. (2007). Primary care nurse practitioners' integrity when faced with moral conflict. *Nursing Ethics, 14*(6), 795-809. 10.1177/0969733007082120 Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-38949193334&doi=10.1177%2f0969733007082120&partnerID=40&md5=f823f40402f2e7193011901c810be073

Laabs, C. A. (2012). Confidence and knowledge regarding ethics among advanced practice nurses. *Nursing Education Perspectives, 33*(1), 10-14. 10.5480/1536-5026-33.1.10 Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-84859412935&doi=10.5480%2f1536-5026-

33.1.10&partnerID=40&md5=cc7e74eba701ff43dddfa44d134f4f20

Lipka, M., & Gecewicz, C. (2017, September 6). More Americans now say they're spiritual but

    not religious. Retrieved from https://www.pewresearch.org/fact-tank/2017/09/06/more-

    americans-now-say-theyre-spiritual-but-not-religious/

Morrow, E., Call, M., Marcus, R., & Locke, A. (2018). Focus on the quadruple aim:

    Development of a resiliency center to promote faculty and staff wellness initiatives. *The*

    Joint Commission Journal on Quality and Patient Safety, 44(5), 293-298. doi://doi-

    org.laneproxy.stanford.edu/10.1016/j.jcjq.2017.11.007

Nurse practitioner salary. (2019, April 7). Retrieved from

    https://www.glassdoor.com/Salaries/nurse-practitioner-salary-SRCH_KO0,18.htm

Poghosyan, L., Liu, J., Shang, J., & D'Aunno, T. (2017). Practice environments and job

    satisfaction and turnover intentions of nurse practitioners: Implications for primary care

    workforce capacity. *Health Care Management Review, 42*(2), 162-171.

    doi:10.1097/HMR.0000000000000094

Pohl, J., Thomas, A., Bigley, M. & Kopanos, T. (2018, December 13). Primary care workforce

    data and the need for nurse practitioner full practice authority. Retrieved

    from https://www.healthaffairs.org/do/10.1377/hblog20181211.872778/full/

Prairie, T. M., Wrye, B., & Murfree, S. (2018). Intersections of physician autonomy, religion,

    and health care when working with LGBT+ patients. *Health Promotion Practice*, 19(4),

    542-549. doi:10.1177/1524839917738974

Radzvin, L. C. (2011). Moral distress in certified registered nurse anesthetists: Implications for

    nursing practice. *AANA Journal, 79*(1), 39-45. Retrieved

    from https://www.scopus.com/inward/record.uri?eid=2-s2.0-

79551581802&partnerID=40&md5=3a27bb39c51ed7c0f0c68990c181a833

Reinhart, R. (2020, January 6). Nurses continue to rate highest in honesty, ethics. (2020).

Retrieved from https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-

ethics.aspx

Robertson, H. D., Elliott, A. M., Iversen, L., & Murchie, P., Matheson, C. (2016). Resilience of

primary healthcare professionals working in challenging environments: a focus group

study. *The British Journal of General Practice*, 66(648), e507–e515.

http://doi.org/10.3399/bjgp16X685285

Rozmus, C. L., Carlin, N., Polczynski, A., Spike, J., & Buday, R. (2015). The Brewsters.

Nursing Ethics, 22(7), 815-826.

doi:http://dx.doi.org.laneproxy.stanford.edu/10.1177/0969733014547974

Rushton, C., Caldwell, M, & Kurtz, M. (2016). Moral Distress: A Catalyst in Building Moral

Resilience. *AJN, American Journal of Nursing, 116*(7)., 40-49.

doi:10.1097/01.NAJ.0000484933.40476.5b

Simmons, A. M., Rivers, F. M., Gordon, S., & Yoder, L. H. (2018). The role of spirituality

among military en route care nurses: Source of strength or moral injury? *Critical Care*

Nurse, 38(2), 61-67. doi:10.4037/ccn2018674

Soleymani-Lehmann, L., Kasoff, W. S., Koch, P., & Federman, D. D. (2004). A survey of

medical ethics education at U.S. and Canadian medical schools. *Academic Medicine, 79*(7),

682. Retrieved

from https://journals.lww.com/academicmedicine/Fulltext/2004/07000/A_Survey_of_Medic

al_Ethics_Education_at_U_S__and.15.aspx

Spetz, J. (2019, May 2). California's nurse practitioners: How scope of practice laws impact care.

Retrieved from https://www.chcf.org/publication/californias-nurse-practitioners/

Straight, K.A. (2018). Leveraging Modern Technology: Ethics Education to Empower

Healthcare Workers and Decrease Moral Distress. (Unpublished master's thesis).

University of San Francisco, CA.

Trautmann, J., Epstein, E., Rovnyak, V., & Snyder, A. (2015). Relationships among moral

distress, level of practice independence, and intent to leave of nurse practitioners in

emergency departments: Results from a national survey. *Advanced Emergency Nursing*

Journal, 37(2), 134-145. 10.1097/TME.0000000000000060 Retrieved

from https://www.scopus.com/inward/record.uri?eid=2-s2.0-

84936763893&doi=10.1097%2fTME.0000000000000060&partnerID=40&md5=44519b1e

df71a93586a8894a5064fd19

Ulrich, C. M., Danis, M., Ratcliffe, S. J., Garrett-Mayer, E., Koziol, D., Soeken, K. L., & Grady,

C. (2006). Ethical conflict in nurse practitioners and physician assistants in managed

care. *Nursing Research*, 55(6), 391-401.

Wands, B. A. (2018). A survey of moral distress in certified registered nurse anesthetists: A

theoretical perspective for change in ethics education for advance practice

nurses. *International Journal of Nursing Sciences*, 5(2), 121-125.

doi:10.1016/j.ijnss.2018.03.006