# Moral Distress in the PICU: Development of a Nursing Intervention

by

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## Abstract

**Background:** There is a desperate need for research-based interventions to help minimize nurses' moral distress, which arises when there is a conflict between what one thinks the morally correct action is and what they are required or capable of doing. While experiences and causes of moral distress have been explored, little is known about how to mitigate the negative effects of moral distress among pediatric critical care nurses. These nurses are the primary caregivers for critically ill and dying children and are highly susceptible to moral distress due to their unique relationship with patients and their families and the daily ethical challenges they may face. Researchers confirm that nurses experience an increase in the intensity of moral distress and pediatric critical care nurses are particularly vulnerable to the phenomenon. Researchers have also demonstrated the negative impact moral distress has on patient care, nurses' health, and nurse retention. Almost half of nurses who experience moral distress consider or leave their position, further impacting patient safety. Further research in effective moral distress interventions is urgently required to improve nurses' working environment, nurse retention and patient care.

**Purpose:** The overarching purpose of my doctoral research was to develop an intervention to mitigate the negative effects of moral distress for PICU and pediatric cardiac intensive care unit (PCICU) nurses. This research consisted of a theoretical paper as the foundation that guides my three-phase research project. The objectives of the research were to: 1) identify existing interventional studies on moral distress and map out research gaps; 2) explore nurses' views on moral distress and their recommendations for attributes of amoral distress intervention; 3) propose and conceptualize the development of a moral distress intervention.

**Methods:** A theoretical paper exploring moral distress through relational ethics is used as the foundation that guides my three-phase study. This multi-phase study is comprised of 1) a scoping review synthesizing moral distress interventions among nurses, 2) a qualitative description study exploring nurses' perspectives and opinions on attributes for a moral distress intervention, and 3) a proposed moral distress intervention applying the findings from phases one and two, and the key elements of relational ethics. The theoretical exploration and subsequent three research phases correspond to the four papers in this dissertation.

**Findings:** Results from the scoping review highlight that there are limited interventional studies for nurses' moral distress. Additionally, there is no clear pattern as to which interventions are effective to minimize moral distress. The qualitative description study reveals what pediatric critical care nurses identify as needed moral distress interventions. Participants stated that interventions to increase supports for patients and families, improve supports for nurses, improve patient care communication and provide education would be beneficial to mitigate their moral distress. Integrated findings from study phases and relational ethics, support the need for a proactive, interdisciplinary townhall meeting as a potential moral distress intervention.

**Conclusion:** This dissertation furthers understanding of moral distress and has laid foundational groundwork to develop an effective intervention to mitigate its effect. This research is the first to synthesize moral distress interventions for nurses, seek nurses' perspectives to identify interventions needed to mitigate their moral distress, and use relational ethics to inform the development of a moral distress intervention. The results of this research can inform needed rigorous intervention development in this area ultimately leading to improved working environments for nurses.

## Preface

This thesis is original work by Sadie Deschenes. The research project, of which this thesis is a part, has received research ethics approval from the University of Alberta Research Ethics Board, title: "Moral Distress in the PICU/PCICU: The Development of a Nursing Intervention" Ethics ID #: Pro00099148, May 7, 2020.

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I was responsible for the conceptualization, writing, and submitting the manuscript. D. Kunyk was my supervisor for this research and contributed to the conceptualization and editing of the manuscript. Both authors made substantial contributions and approved the final manuscript.

Chapter three of this thesis has been published as: Deschenes, S., Tate, K., Scott, S. D., & Kunyk, D. (2021). Navigating the experiences of moral distress: A scoping review. *International Journal of Nursing Studies*, 104035. https://doi.org/10.1016/j.ijnurstu.2021.104035

I was responsible for the conceptualization, development of the search strategy (alongside a research librarian), screening, data extraction and analysis, writing, and submitting the manuscript. K. Tate assisted with screening, data extraction and revisions of the manuscript. S.D. Scott and D. Kunyk were my supervisors for this research and contributed to the conceptualization and editing of the manuscript. All authors made substantial contributions and approved the final manuscript.

Chapter four of this thesis has been submitted for publication as: Deschenes, S., Kunyk, D., & Scott, S. (2021). Mitigating moral distress: Pediatric critical care nurses' recommendations. *International Journal of Nursing Studies.* I was responsible for the

conceptualization of the study as well as recruitment, data collection, data analysis, writing and submitting this manuscript. D. Kunyk and S.D. Scott were my supervisors for this research and contributed to the conceptualization and editing of the manuscript. All authors made substantial contributions and approved the final manuscript.

Chapter five of this thesis is being prepared for submission as: Deschenes, S., Kunyk, D., & Scott, S. Developing an evidence-and-ethic informed intervention for moral distress. Target journal is *Nursing Inquiry.* I was responsible for conceptualizing and writing the manuscript. D. Kunyk and S.D. Scott were my supervisors for this research and contributed to the conceptualization and editing of the manuscript. All authors made substantial contributions and approved the final manuscript.

**Dedication**

To my brother and friend, Justin Walter Deschenes

1982-2022

Throughout my whole life you have always believed in me and made sure that I knew it.

Though you never had a chance to see this in its entirety,

you are here in every page.

**Acknowledgements**

"No one who achieves success does so without the help of others. The wise and confident acknowledge this help with gratitude."
– Alfred North Whitehead

I want to acknowledge the nurses who generously gave up their time to talk to me. I am grateful you trusted me with your stories and am honoured to learn from your experiences, thank you.

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To my dear friends: Meaghan Rondeau, Jen Wong and Kaitlyn Tate, thank you for supporting me through these last five years. I hope you recognize how much your support means to me.

To my amazing family: Mom, Dad, Danielle, Julie, Joe and Cleo, thank you for listening to me, and for your endless support and love.

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## Table of Contents

## List of Tables

## List of figures

## List of Abbreviations

**Moral distress (MD)**: “arises when nurses are unable to act according to their moral judgment. They feel they know the right thing to do, but system structures or personal limitations make it nearly impossible to pursue the right course of action” (Canadian Nurses' Association, 2017).

**Pediatric Intensive Care Unit (PICU):** is a dedicated unit to provide care to critically ill infants and children with non-cardiac diseases (Alberta Health Services, 2019).

# Chapter 1 Situating the Research

## Moral Distress

Nurses are experiencing unprecedented levels of moral distress due to the global pandemic and new unforeseen challenges in their daily work (Morley, Sese, et al., 2020). While the term moral distress was first described by Andrew Jameton in 1984, it is of growing concern since the onset of Covid-19 due to increased demands on already limited resources. Moral distress occurs when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (1984, p. 6). There is an ongoing debate on how to define moral distress. However, basic tenants of the definition include a moral event where constraints are explicitly or implicitly stated, and one experiencing phycological distress (Deschenes, et al., 2020; Morley, Bradbury- Jones, et al., 2020).

### *Causes and Effects of Moral Distress*

Causes of moral distress are specific to the individual, the situation and the environment. A situation where one may experience profound moral distress can leave another unaffected (Austin, Rankel et al., 2005; Deschenes & Kunyk, 2020). However, common causes of moral distress have been identified and include adequacy of care provided by other healthcare providers, futile care (particularly surrounding end of life), communication problems, challenges surrounding end of life care, lack of support, and power dynamics among the healthcare team (Burston & Tucket, 2012; Colville et al., 2019; Henrich et al., 2016; Lamiani et al., 2017). Nurses are unique in that they have a great deal of responsibility, low decision-making capacity, and the intimate nature of the nurse-patient relationship. For these reasons nurses experience a higher intensity of moral distress compared to other healthcare professionals (Austin, Lemermeyer, et al., 2005; Cavaliere, et al., 2010; Larson, et al., 2017; Whitehead et al., 2015).

The negative effects of moral distress have been widely discussed and include effects on the individual, patients, and the healthcare system. Individuals can experience negative emotional (feelings of powerlessness, fear, anxiety, etc.), spiritual (crisis of faith, loss of self-worth etc.), behavioural (agitation, forgetfulness, avoidance etc.) and physical symptoms (heart palpitations, headaches, insomnia etc.) due to moral distress (Rushton, Caldwell et al., 2016). Patient care can be negatively affected resulting in poor quality care, decreased satisfaction, and medication errors due to the healthcare provider's inability to cope effectively (Dekeyser Ganz & Berkovitz, 2012; Henrich, et al., 2017; Maiden, et al., 2011; Morley, Bradbury-Jones et al., 2020). Lastly, moral distress has a profound negative impact on the healthcare system due to issues with retention and attrition (Austin et al., 2017; Colville et al., 2019; Nathaniel, 2006). In one study with ICU nurses, almost half (45%) either left their position or considered leaving due to moral distress (Hamric & Blackhall, 2007). Similarly, in a grounded theory study by Nathaniel (2006), moral distress resulted in 43% of nurses either leaving their position or the profession. Moral distress, when combined with professional stress, was predictive of nurses' intent to stay at their current institution (Cummings, 2011). In Alberta, within one year, over 2,400 cases of the phenomenon were reported to a union representing ~ 30,000 nurses (McIntosh, 2015). With the effect moral distress has on retention, it impacts the current nursing shortage (Nathaniel, 2006) and this shortage has been labeled a "human resource crisis" (Marć et al., 2019). However, moral distress has been shown to have some benefits if resolution occurs. It can be a catalyst for personal and professional growth, clarity and insight in one's nursing practice, self-reflection, advocacy, and preparation of nurses for future situations (Canadian Nurses' Association, 2017; Green & Jeffers, 2006; Webster & Baylis, 2000). Even with these profound consequences, the level of moral distress awareness is up for debate. According to some, moral distress is part of

nurses' everyday language (McCarthy & Deady, 2008; Varcoe et al., 2012). However, others state that it is unfamiliar to nurses and the concept is not commonly used within clinical practice (Austin et al., 2003; Austin, Rankel et al., 2005; Prentice et al., 2016; Ritchie et al., 2018). Due to the profound effects moral distress has on nurses, patient care, and the healthcare system, strategies to mitigate the phenomenon's negative effects are needed.

### *Moral Distress within Pediatric Critical Care*

Medical and technological advances have led to a significant decrease in mortality rates within pediatric critical care units (Namachivayam et al., 2010). These life-saving advances can lead to long term sequalae of the survivors and can leave healthcare professionals questioning if they caused more harm than good (Garros et al., 2015). Specifically, within pediatric critical care, moral distress has primarily resulted from disproportionate interventions believed not to be in the patient's best interest and is associated with provider burnout, uncertainty of health outcomes, or what is considered right, and feeling unsupported (Larson et al., 2017; Prentice et al., 2016). According to Prentice et al., (2016), moral distress also affects patient care due to the emotional burden it has on individual nurses. These nurses may abandon the PICU thereby leaving the unit understaffed. Studies have shown that moral distress is experienced more frequently in pediatric and neonatal intensive care units compared to adult intensive care units or pediatric wards (Prentice et al., 2016). Additionally, nurses report a higher intensity of moral distress when compared to physicians working in these units (Larson et al., 2017).

### *Moral Distress Research*

Moral distress research has focused primarily on the experiences and causes of moral distress among nurses (e.g., Austin, Bergum et al., 2003; Dekeyser Ganz & Berkovitz, 2012; Edwards et al., 2013; Gagnon & Kunyk, 2021; Lake et al., 2021; Ritchie et al., 2018; Sauerland

et al., 2015; Varcoe et al., 2012; Wilkinson, 1987), developing tools to measure and validate moral distress (e.g., Corley et al., 2001; Hamric et al., 2012, Wocial & Weaver, 2013) and theoretical aspects of the phenomenon (e.g., Deschenes et al., 2020; Deschenes & Kunyk, 2019; Morley, Ives et al., 2021; McCarthy & Deady, 2008). This research has branched out to include other healthcare professionals such as physicians, social workers, respiratory therapists, and professionals outside of the healthcare system such as military personnel, police officers, and teachers (Aguirre-Kuehl, 2021; Browning & Cruz, 2018; Colnerud, 2015; Currier et al., 2019; Mänttäri-van der Kuip, 2012; Papazoglou & Chopko, 2017; Sheather & Fidler, 2021).

Moral distress research is now starting to move towards identifying and developing interventions to mitigate the phenomenon's negative effects. Unfortunately, there is limited evidence on specific approaches or interventions to minimize nurses' moral distress. While many interventions (such as education on ethics, skills, communication, self-reflection; mentorship and supportive organizational culture) have been proposed (Burston & Tuckett, 2013), limited interventional studies have been conducted and further research, especially in preventative solutions and interventions in the workplace are needed (Corley, 2002). Further work on this topic is critical to prepare nurses to harness their experiences of moral distress in a way that benefits their personal growth, the profession and the public they serve (Pendry, 2007). Researchers suggest interventional programs that focus on areas most prone to the effects of moral distress (such as the PICU) will have a greater impact on affecting change (Dryden-Palmer et al., 2019; Pendry, 2007).

**Philosophical and Theoretical Foundations**

Ontology is the assumption about the nature of beings. In nursing "we use ontology to mean a study and critical analysis of the very nature –the core–of beings, relations, and

concepts" (Meleis, 2011, p. 27). Epistemology looks at what can be known and how knowledge can be defined or developed (Meleis, 2011). Nursing values a pluralistic approach in terms of both ontology and epistemology (Giuliano et al., 2005). Giuliano et al. (2005) argue that it is through multiple perspectives that nursing knowledge can be developed in its totality and truth is dependent on one's experiences, principles and the context of the situation. Similarly, Risjord (2011), states that it is only through plurality that effective nursing can be promoted. In my research, I have adopted a pluralistic epistemological approach, which I view as necessary with moral distress research. This approach supports the integration of many different perspectives and experiences (Giuliano et al, 2005) and it is these differences in perspectives that lead to moral distress. A pluralistic approach is also congruent with a qualitative description research approach. The use of qualitative description offers a low-inference, comprehensive description of events suitable for researchers seeking an accurate account of a phenomenon (Sandelowski, 2000). This method favours a naturalistic descriptive approach over interpretation. Researchers utilizing this approach seek to portray the accounts with minimal inference and the description result in an easier consensus among researchers and participants (Sandelowski, 2000). Additionally, relational ethics will be integrated throughout my doctoral research and is discussed in the following section.

### *Relational Ethics*

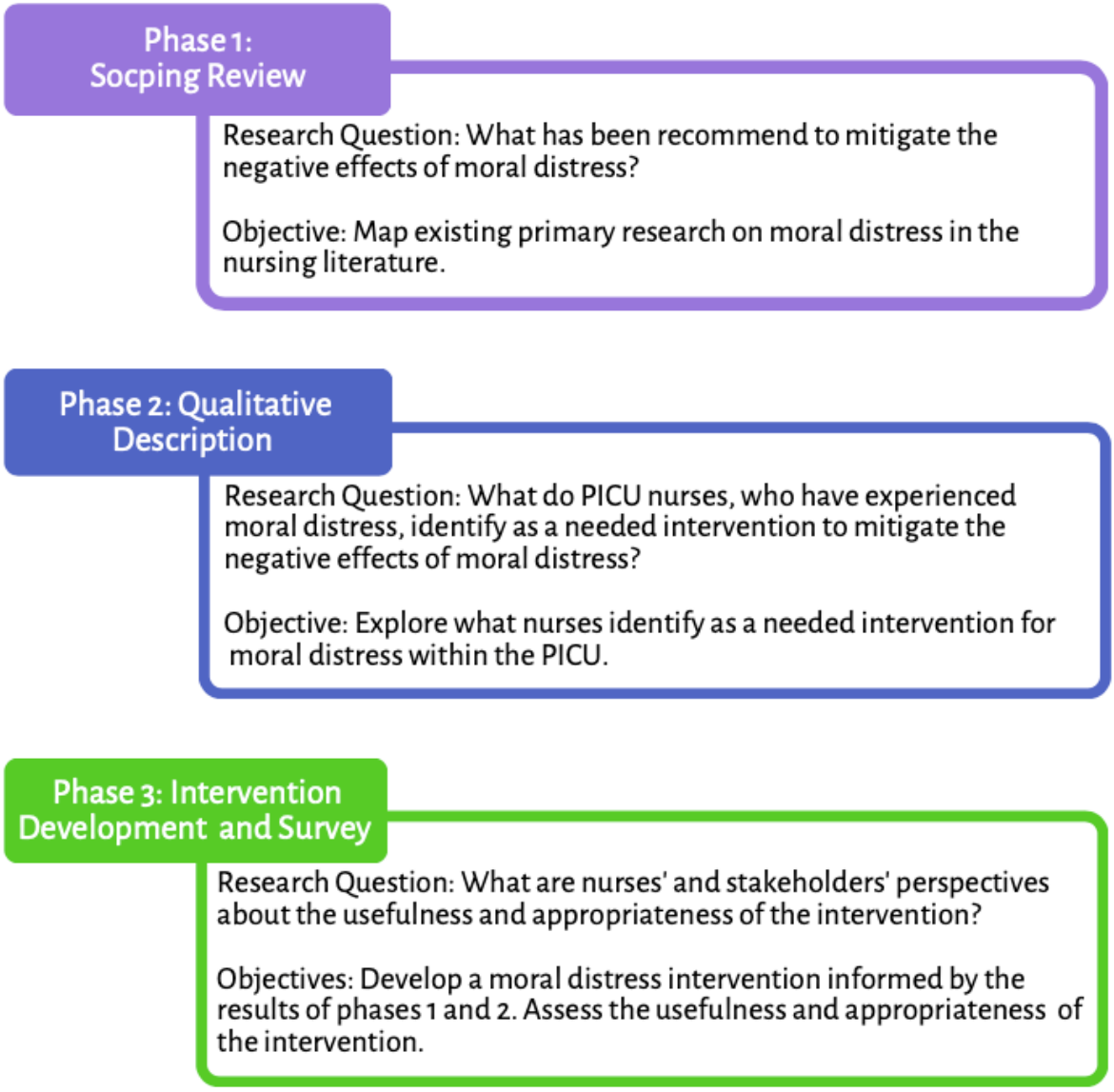
My doctoral research was guided by relational ethics. This ethic is an action ethic that acknowledges the importance of ethical moments and the relationships that exist in those moments (Bergum & Dossetor, 2020). Relational ethics considers each individual involved in the encounter, the relationships among those individuals, as well as the environment that surrounds them. This ethic recognizes that ethical situations are not objective and because of this, there is

not always one clear, morally correct outcome (Bergum & Dossetor, 2020). Relational ethics applies a pluralistic view where moral space is created by the relationships involved in each situation (Austin & Kent-Wilkinson, 2019; Kunyk & Austin, 2012). This ethic is most informative in guiding the day-to-day ethical moments that occur between people where unethical actions are not obvious, or a decision needs to be made between the better of two bad options. This ethic provides a lens through which we can view each morally distressing situation because it recognizes that ethical practice is situated within relationships yet considers the broader environmental influences on ethical action (Deschenes & Kunyk, 2019). Relational ethics may be the only way to approach situations where differences of opinions, beliefs, and values occur (Bergum & Dossetor, 2020).

**Dissertation Phases, Methods, and Objectives**

The overarching goal of my doctoral research is to propose an intervention to mitigate the negative effects of moral distress for PICU nurses. To achieve this goal, I developed a three-phase research project, and this paper-based dissertation represents the output from my doctoral program. The phases, methods and objectives are described in Figures 1.1 and 1.2.

**Figure 1-1. Proposed Research Phases, Methods, and Objectives**

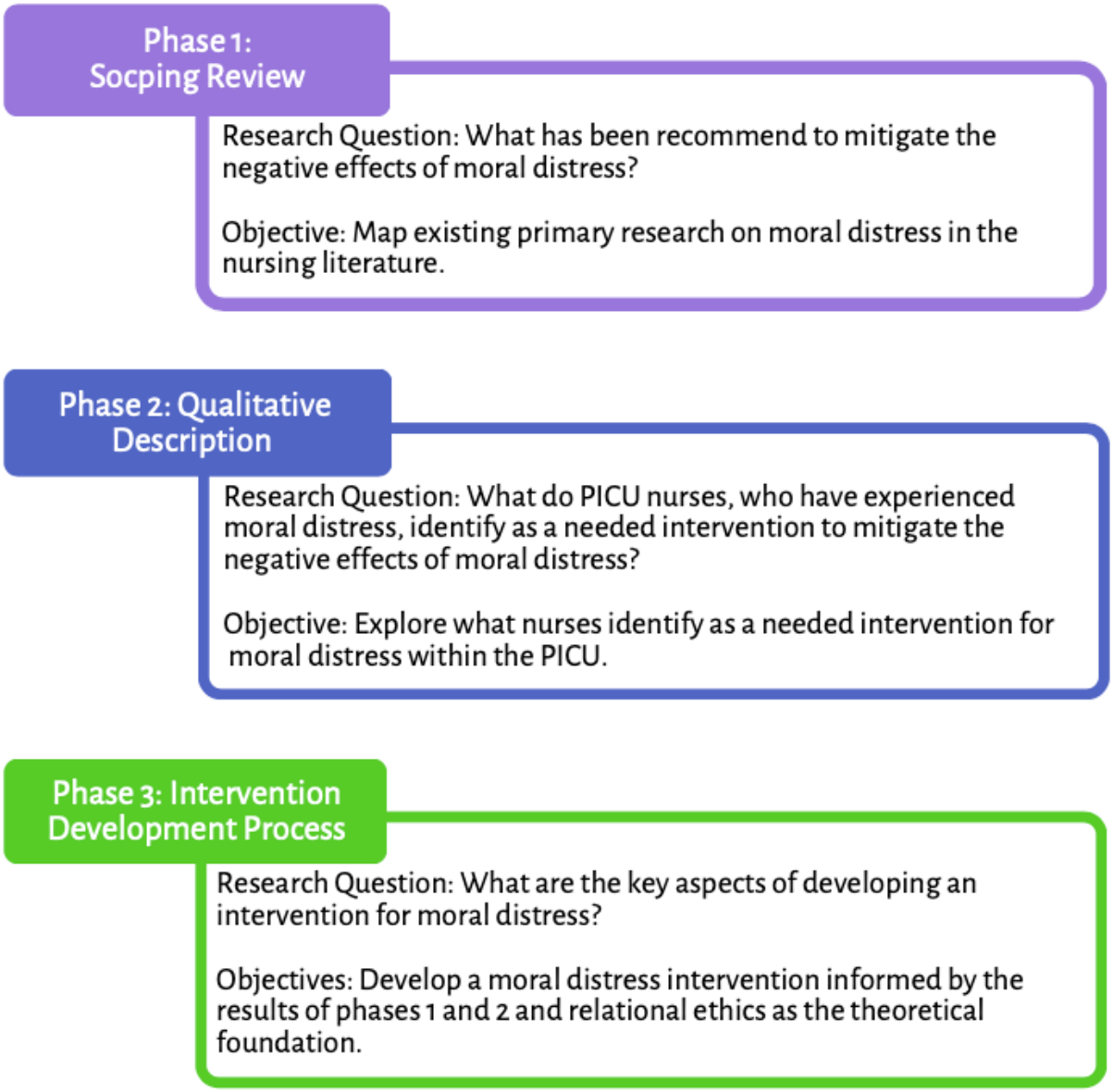


**Dissertation Adaptations**

In March 2020, the global pandemic changed our world including how we lived, studied, worked, and interacted with one another. At this time, I finalized my research proposal, was preparing for my candidacy exam, and finalizing my ethics submission for my doctoral research. Where this research took place, specifically at the University of Alberta and University of Alberta Hospitals, a work from home mandate was in place for non-essential staff, restrictions to the hospital were limited to essential personal only, and non-essential research was put on hold to process priority announcements related to the Covid-19 pandemic. The hospital infrastructure was overwhelmed, hospital staff were re-deployed to essential units (i.e., emergency department, intensive care units, Covid testing and screening, etc.), and healthcare providers were asked to take on more work than before.

Consequently, I adapted my ethics application to include virtual data collection and otherwise planned to continue my research as outlined in my proposal. Recruitment of registered nurses working in pediatric critical care proved to be challenging. I started my data collection in Fall of 2020 and over two months completed only 3 interviews. In May 2021, I was able to complete my data collection, interviewing a total of 10 participants. After discussing my progress and upcoming plans for my research with my committee, we decided to eliminate further participant recruitment and therefore forgo the development and feasibility testing of the intervention. This phase was replaced with a theoretical discussion detailing how the intervention should be developed taking in to account the findings from phases one and two of my research.

**Figure 1-2 Amended Research Phases, Methods, and Objectives**




**Dissertation Overview**

My dissertation comprises four distinct but related papers that focus on the development of a novel moral distress intervention for pediatric critical care nurses. Each paper has been formatted to the specific journal where they have been/will be published or submitted. The first paper (chapter 2) is a theoretical paper exploring the concept of moral distress through a

relational ethics lens. This paper was published prior to the development of my research proposal but is foundational to the performance of the research project. Earlier versions of this manuscript were submitted as part of my coursework, however substantial development occurred post the course.

The second paper is a scoping review examining the current moral distress interventions among nurses providing direct patient care. This review provides foundational knowledge to assess current moral distress interventions and their effect. The third paper describes the qualitative description study I conducted to better understand what nurses working in pediatric critical care need to help mitigate their moral distress. The final paper outlines how a moral distress intervention should be developed and pulls in the findings from the previous two phases. Below, I provide a brief summary of each paper and how they are connected.

***Paper 1***

Description: The first paper identifies the possibility relational ethics has to serve as a lens to advance our knowledge of moral distress. It discusses nurses as moral agents in the context of moral distress, briefly explores ethics in nursing, and suggests why relational ethics should be used in nurses' daily ethical interactions. Finally, this paper explores how nurses' experiences of moral distress can be examined through the key elements of relational ethics to support nurses' ethical practice.

Connection to the larger dissertation purpose: Paper one is the first paper to explore moral distress through a relational ethics lens and therefore emphasizes the need for this connection to advance our nursing knowledge. This paper lays the theoretical groundwork necessary to conduct my research project and is used throughout subsequent research phases.

Paper one (Chapter 2) has been published as: Deschenes, S., & Kunyk, D. (2020). Situating moral distress within relational ethics. *Nursing Ethics*, 27(3), 767-777. https://doi.org/10.1177/0969733019884621

***Paper 2***

Description: This paper is the first to synthesize interventional studies on moral distress and highlight the lack of studies among nurses who provide direct patient care. The aim of this scoping review is to comprehensively identify moral distress interventions for direct patient care nurses, identify gaps in the existing body of knowledge, and propose areas for future studies. We follow Levac and colleagues' (2010) framework to systematically search published research studies. Ten studies met all inclusion criteria. The findings demonstrate that there are no clear patterns as to which strategies consistently minimize nurses' moral distress. See appendix A, B, and C for the study information letter, draft interview guide, and demographic questionnaire.

Connection to the larger dissertation purpose: Paper two identifies the lack of effective and validated interventions for moral distress by comprehensively identifying and synthesizing the current evidence. We suggest future studies should increase the sample size, include units other than acute care units, and include other healthcare professionals. It would also be helpful to standardize how the *Moral Distress Scale- Revised* (Corley et al., 2001) scores are reported so researchers could compare results. Further, we conclude that future studies should also examine additional endpoints such as those related to patient outcomes (Deschenes, Tate et al., 2021). Results from this study contribute to the suggested development of an evidence and ethic informed moral distress intervention.

Paper two (Chapter 3) has been published as: Deschenes, S., Tate, K., Scott, S. D., & Kunyk, D. (2021). Navigating the experiences of moral distress: A scoping review. *International Journal of Nursing Studies*, 104035. https://doi.org/10.1016/j.ijnurstu.2021.104035

***Paper 3***

Description: Paper three examines the perspectives and opinions of pediatric critical care nurses to identify effective solutions towards improving their working lives related to moral distress. The purpose of this study is to identify what critical care nurses who have experienced moral distress identify as a needed intervention to mitigate moral distress. In this paper we use a qualitative description approach. Semi-structured one-on-one interviews were conducted via Zoom to explore participants perspectives. A total of 10 registered nurses participated in this study. Four main themes are identified: 1)*"I'm sorry, there's nothing else": increasing supports for patients and their families*; 2) "*someone will commit suicide": improving supports for nurses* with subthemes a) *receiving help to navigate their psychological and emotional distress;* and b) *strategies to build morale and enhance unit culture;* 3) *"everyone needs to be heard": improving patient care communication*; and 4) *"I didn't see it coming": providing education to mitigate moral distress.*

Connection to the larger dissertation purpose: This is the first study that asks front line nurses what they need to minimize their moral distress. The results show that most nurses wanted interventions to improve communication among the health care team. Other interventions that participants stated could minimize their moral distress include increasing moral distress education, enhancing unit culture, and improving supports for both nurses and the families. Details of strategies to minimize nurses' moral distress are presented and contribute to the proposed development of a moral distress intervention.

Paper three (Chapter 4) has been submitted for publication as: Deschenes, S., Kunyk, D., & Scott, S. (2021). Mitigating moral distress: Pediatric critical care nurses' recommendations. *International Journal of Nursing Studies.*

***Paper 4***

Description: Interventions to mitigate the negative effects of moral distress are vital to improve the health of the nurse, patient care, and the workplace environment. This descriptive paper conceptualizes the development of an evidence based, etic informed moral distress intervention. Relational ethics is used as the foundational lens and embedded within the framework of the intervention. This ethic as well as the findings from phases one and two of this research study are used to guide the development of this intervention.

Connection to the larger dissertation purpose: This paper pulls together the findings from papers one, two, and three to guide the development of an evidence-and-ethic informed moral distress intervention. Future research directions to actualize this intervention are detailed. Now more than ever effective strategies to minimize the negative effects of moral distress are needed. This research program has the potential to make a meaningful contribution to the daily working lives of nurses.

Paper four (Chapter 5) is being prepared for submission as: Deschenes, S., Kunyk, D., & Scott, S. (2021). Developing an evidence-and-ethic informed intervention for moral distress. *Nursing Inquiry.*

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## Chapter 2 Paper 1: Situating Moral Distress Within Relational Ethics


### Abstract

Nurses may, and often do, experience moral distress in their careers. This is related to the complicated work environment and the complex nature of ethical situations in everyday nursing practice. The outcomes of moral distress may include psychological and physical symptoms, reduced job satisfaction, and even inadequate or inappropriate nursing care. Moral distress can also impact retention of nurses. Although the research on moral distress has grown considerably over the past few decades, there is still a great deal about this topic that we do not know including how to deal well with moral distress. A critical key step is to develop a deeper understanding of relational practice as it pertains to moral distress. In this paper, exploration of the experience of moral distress amongst nurses is guided by the key elements of relational ethics. This ethical approach was chosen because it recognizes that ethical practice is situated in relationships and it acknowledges the importance of the broader environment on influencing ethical action. The findings from this theoretical exploration will provide a theoretical foundation upon which to advance our knowledge about moral distress.



**Keywords:** Ethics, Moral distress, Nursing, Relational ethics

## Introduction

Nurses are moral agents with the responsibility to conduct themselves ethically and provide ethical care. Codes of ethics for nurses are developed to provide guidance for ethical situations and to inform nurses of the moral responsibilities to which they are bound (Canadian Nurses Association [CNA], 2017; International Council of Nurses [ICN], 2012). However, due to the complex work environment and nature of ethical situations in everyday practice, codes of ethics alone cannot ensure ethical practice (CNA, 2017). Nurses are not always able to provide patients with the care they need due to these complexities, and therefore the professional goals of nurses cannot be achieved. When this occurs, nurses may experience moral distress (Corley, 2002). This phenomenon can include a wide range of feelings such as anxiety, despair, worthlessness, resentment, and anguish. Reports of moral distress are increasing as is our understanding of its numerous effects on nurses, patient care, the healthcare system and the nursing profession (Austin, Rankel et al., 2005; Corley, 2002). Although the research on moral distress has grown considerably over the past few decades, there is still a great deal about this topic that we do not know particularly, effective interventions to address moral distress. A critical key step is to develop a deeper understanding of relational practice as it pertains to moral distress.

A deeper understanding of relational practice, and relational ethics as it pertains to moral distress, may guide our actions. Relational ethics is an action ethic that recognizes the significance of close up ethical moments and the relationships that exist in those moments. It focuses on each person as a whole in the encounter, the connection between the individuals, and the environment that surrounds them (Bergum & Dossetor, 2005). The importance of relationships in nursing and relational ethics, and the lack of specific direction in making ethical

decisions from codes of ethics, has guided us to ask, “could relational ethics serve as the theoretical lens through which to explore and address moral distress?”

In this paper, we will demonstrate how moral distress in nursing can be examined through a relational ethics lens. First, the moral agency of nurses will be discussed to explain how nurses may experience moral distress. Next, a definition of moral distress and its key characteristics, and the rising concerns with moral distress, will be presented. Furthermore, we will provide a brief overview of ethics in the nursing context and then introduce relational ethics and its key elements. Finally, we will explore the possibility of relational ethics in advancing our knowledge of moral distress.

**Nurses as Moral Agents**

Nursing practice is inherently ethical. The foundation of the nursing profession is grounded in disciplinary standards, codes of ethics, and values of beneficence, empathy, compassion, conscientiousness, and integrity (Austin, 2016; CNA, 2017; Corley, 2002). An important part of nursing includes ethical dilemmas or difficulties (Yildiz, 2019). Nurses work with vulnerable patients and face ethical challenges surrounding patient care situations daily (Corley, 2002; Nathaniel, 2006). These daily ethical situations become part of nursing work and their significance often goes unrecognized (Austin, 2007). The Canadian Nurses Association (CNA) explicitly states, “nurses need to recognize that they are moral agents in providing care” (CNA, 2017, p. 5). When nurses are not able to conduct themselves in an ethical manner due to the realities of the workplace, their identity as a health professional is undermined and nurses can experience moral distress (Austin, 2012; Corley, 2002; Nathaniel, 2006).

**Moral Distress in Nursing**

Moral distress originated as a philosophical term described for the first time by Andrew Jameton in 1984. He described moral distress as a situation "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6). Since that time, the literature on moral distress has grown significantly and numerous definitions of moral distress have been generated. More recently, the CNA has defined moral distress as a situation where nurses "feel they know the right thing to do, but system structures or personal limitations make it nearly impossible to purse the right course of action. Moral distress can lead to negative consequences such as feelings of anger, frustration and guilt, yet it can also be a catalyst for self-reflection, growth and advocacy" (2017, p. 6).

The prevalence of moral distress internationally is understudied. In one cross sectional study in Saudi Arabi the frequency of severe moral distress among health care providers was 24.3% and mild moral distress was 75.7% (Almutairi et al., 2019). In one Canadian province, approximately 2,400 cases of moral distress were reported to the union representing 30,000 nurses (McIntosh, 2015). Without the awareness of moral distress, it is difficult for nurses to report cases of it. The level of awareness of this phenomenon among nurses is still up for debate. Some authors suggest that moral distress is part of nurses' everyday vocabulary and is so ubiquitous within nursing that its definition is in the *Code of Ethics for Registered Nurses* (McCarthy & Deady, 2008; Varcoe et al., 2012). Yet other authors state that moral distress is not being talked about enough because it is not a term familiar to most nurses (Austin et al., 2003; Austin, Rankel, et al., 2005). In fact, one study showed that nurse practitioners were unaware that they had even experienced moral distress (Ritchie et al., 2018).

Included in the moral distress literature is a proposed theory on the phenomenon presented by Corley. This theory was designed to clarify what happens when a nurse is unable to

act as a moral agent and therefore experiences moral distress. Internal and external contexts are considered with particular attention paid to the work environment (Corley, 2002). In this theory, Corley (2002) states that medical ethics provides limited direction and acknowledges the importance of relationships in these difficult situations. Although this theory proposes a research agenda, it does not provide guidance for nurses to act upon in their day-to-day practice. One key piece that is lacking in this theory, and in the large body of literature on moral distress, is exploration of moral distress through the key elements of relational ethics. This will be discussed in detail later.

### *Attributes of Moral Distress*

Moral distress is not predetermined or inevitable; it occurs due to a specific situation in combination with a nurse's belief system (Austin et al., 2003; Austin, Lemermeyer et al., 2005; Wilkinson, 1987). Internal and external factors contribute to moral distress. Internal factors include feelings of powerlessness, inadequacy and fear, as well as feeling conflicted having to choose between the institution and the patient (Austin, Lemermeyer, et al., 2005; Austin, 2012; Austin, 2016; Kälvemark et al., 2004; Prentice et al., 2016). External factors include power dynamics or unequal hierarchies within the institution, lack of resources and support, complex patient/family care, excessive use of technology, and conflicts among the team (Austin et al., 2009; Austin, 2016; Burston & Tuckett, 2013; Kälvemark et al., 2004; Jameton, 1993; Huffman & Rittenmeyer, 2012; Lamiani et al., 2017). Although morally distressing situations is unpredictable, moral distress is more likely to occur in situations concerned with medically prolonging life, unnecessary pain and suffering of the patient, objectification of patients, constraints in health policy, inadequate staffing, challenging professional and inter-professional

relationships, and limited resources due to cost constraints (Austin, 2012; Corley, 2002; Wilkinson, 1987).

### *Consequences of Moral Distress*

Moral distress may significantly affect nurses, both psychologically and physically. Some of the psychological symptom's nurses could experience include decreased self-esteem, loss of integrity, and feelings of anger, fear, sadness, numbness, frustration, depression, misery, and guilt (Austin, Rankel, et al., 2005; Austin, et al., 2009; Corley, 2002, Huffman & Rittenmeyer, 2012; Jameton, 1993; Nathaniel, 2006). Physical symptoms include loss of appetite, nausea, diarrhea, migraines, and heart palpitations (Austin, et al., 2009; Hanna, 2005; Jameton, 1993).

The effects of moral distress, however, reach far beyond the nurse. Moral distress can also affect patient care and the health care system as a whole. If a nurse develops ineffective coping strategies to deal with a morally distressing situation, he or she can lose the ability to provide good patient care emotionally withdraw from patients, and even avoid patients altogether (Austin, Lemermeyer, et al., 2005; Huffman & Rittenmeyer, 2012; Wilkinson, 1988). This can lead to poor patient care, an increased length of stay for a patient, and decreased patient satisfaction (Burston & Tuckett, 2013; Dekeyser Granz & Berkavitz, 2012). Moral distress may also be a contributing factor to the critical nursing shortage (Austin, et al., 2009; Cummings, 2011; Nathaniel, 2006). It has been reported that moral distress has implications for not only job satisfaction, but also recruitment and retention (Pauly et al., 2012). In an early grounded theory study of 21 registered nurses, Nathaniel (2006), found that 43% of nurses have left a position due to morally distressing situations. The nursing shortage can further negatively impact patient care. Due to the fundamental ethical nature of moral distress, it needs to be examined through an ethical lens in hopes to further develop our knowledge of the phenomena.

**Ethics and Morals in the Nursing Context**

Ethics is "the discipline dealing with what is good and bad and with moral duty and obligation" (Merriam-Webster, 2019) and it commonly refers to the values and standards to which an individual or a profession strives to achieve (Raffin Bouchal & Ecker, 2006). Ethics is about understanding how to reach our potential as humans (Austin & Kent-Wilkinson, 2019). The tenets of moral philosophy, on the other hand, examine ways an individual may approach decisions about how to act in a given situation. The principles of moral philosophy therefore act as a guide for nurses and provide a foundation for the nurse in making logical and ethical decisions (Austin & Kent-Wilkinson, 2019). Signs of a moral situation are often feelings such as guilt, hope, or shame, or responding to a situation with words such as ought, should, right, wrong, good and bad (Stephens & Brighton, 2014). The terms morals and ethics are often used interchangeably (Austin & Kent-Wilkinson, 2019; Stephens & Brighton, 2014), and will be used interchangeably throughout this paper.

Nurses are often faced with ethical situations in practice. In Canada, the CNA's *Code of Ethics for Registered Nurses* (CNA, 2017) set the ethical standards for nursing practice. It identifies the seven foundational nursing values that are required to provide ethical nursing care: providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making; honouring dignity; maintaining privacy and confidentiality; promoting justice; and being accountable (CNA, 2017, p. 3). These values provide guidance for nurses in all contexts experiencing ethical challenges that arise in practice (ether with a patient or colleague). They form the basis for all professional relationships in nursing. However, due to the complexity of ethical situations in practice, codes of ethics cannot be used alone (CNA, 2017). According to Risjord (2010), ethical codes demonstrate

professional commitment yet provide little guidance in nursing practice because they are too abstract.

Traditionally, nursing ethics has been greatly influenced by bioethics, a dominant ethic in the medical community (Gastmans, 2013). Bioethics was specifically developed to address health care related issues. It follows four guiding principles: autonomy, non-maleficence, beneficence, and justice. According to this ethic, health care providers are to prioritize these principles in a given situation and act accordingly (Raffin Bouchal & Ecker, 2006; Stephens & Brighton, 2014). Critiques of bioethics argue that it does not reflect everyday ethical situations that nurses often find themselves in or take into account the relational nature of these situations (Austin, 2007; Moore et al., 2014). Often nurses' difficulty is not in determining what the right course of action is, the difficulty lies when the choice is apparent, but nurses are not able to implement the morally acceptable action (Austin, Lemermeyer, et al., 2005). Moral distress occurs within the context of the environment and the relationships within that environment matter. We, as nurses, need an ethical approach that is better suited to the complexities that occur in what could be morally distressing situations.

**Relational Ethics and Moral Distress**

Relational ethics is an action ethic based on the assumption that ethical practice is situated in relationships. These relationships are the inherent foundation of relational ethics. Within this understanding, ethical situations are not viewed as completely objective and therefore, there is no clear correct outcome in relational ethics. It is viewed as pluralistic and the moral space is created by the relationships involved in each situation (Austin & Kent-Wilkinson, 2019; Bergum, 2004; Kunyk & Austin, 2011). Relational ethics does not serve as a guide for dramatic ethical conflicts (e.g. which patient should receive the transplant) or blatantly unethical

actions. In these situations, there are checks and measures in place such as regulatory bodies, ethic review boards, and the legal system. Relational ethics is most informative in guiding the day-to-day ethical moments that occur between people.

Relational ethics requires a commitment to care about those involved in the situation and to actively engage in the relationship. The individual nurse strives to be responsive in each situation and offers genuine communication that fosters mutual respect among everyone involved. Feelings and emotions are explored because they are seen as part of the process, as opposed to something that gets in the way of one's thinking (Austin & Kent-Wilkinson, 2019). Critics of this ethic may state that it is unstructured, lacks the control that can be found in other ethical approaches, and that anything can be right or wrong depending on the situation.

However, cultivating the moral space may be the only way to ethically approach situations where differences in beliefs, values, and cultures occur (Bergum & Dossetor, 2005). Relational space is the location where acting morally occurs, where ethics needs to be considered in every situation with every patient. When attention is paid to the quality of relationships, one must "focus on the kind of relationships that allow for the flourishing of good rather than evil, trust rather than fear, difference rather than sameness, healing rather than surviving and so on" (Bergum, 2004, p. 487). It is through the core elements of relational ethics that a moral space can be achieved. These core elements are mutual respect, engagement, embodied knowledge, and interdependent environment. These elements will be described below.

### *Mutual Respect*

Mutual respect is the central theme of relational ethics. It arises from the realization that we are all fundamentally connected to each other. Our experiences are shaped by the attitudes and actions of others towards us, in the same way our actions and attitudes shape others. Mutual

respect acknowledges differences such as power, knowledge, beliefs, values, experiences, and attitudes and looks for ways that people can to work together with these differences. It requires us to first respect ourselves so we can interact in a respectful way with others (Bergum, 2004). For mutuality to occur, we need to be present in both the mind and in the heart. It requires us to be self-interested and at the same time interested in the other. Respecting ourselves requires self-awareness knowing our values, beliefs, and knowledge. Knowing ourselves, in turn, allows us to know how we respond in a specific situation and we begin to understand ourselves in relation to others. It is from a place of self-respect that we can learn to respect others. This is not a linear process as both self-respect and respect of others can be learned at the same time. Respecting others does require truly listening, addressing by name, and taking a conscious effort to make a connection (Bergum & Dossetor, 2005). Respect for others does not require agreement; it requires recognition of the others humanness and taking any differences seriously. It means having a conversation with someone rather than gathering information (Bergum & Dossetor, 2005).

Treating individuals respectfully is foundational in nursing and it is involved in every nursing situation and in every encounter with patients and other healthcare professionals (Austin, 2007; Austin & Kunyk, 2011; Bergum, 2004). It is an essential aspect of teamwork and necessary for a team to coexist with differences (Bergum, 2004). Mutual respect is vital in the context of moral distress because it acknowledges differences in power which can greatly affect situations when there are differences in opinions and/or values. This power differential is deep-rooted within the healthcare system and is commonly attributed to moral distress. In the moral distress literature, power differentials are typically labeled as “external” or “institutional” constraints. It limits nurses’ abilities to act according to their personal or professional values and

beliefs. This power difference can take many forms in morally distressing situations such as nurses being unable to voice their concerns or advocate for patients, lack of recognition of the nurses' knowledge, and devaluing the perspectives of nurses (McCarthy & Deady, 2008). For this reason, it is critical to approach moral distress in a way that addresses power differentials (Peter & Liaschenko, 2013).

From a relational ethics perspective, mutual respect mitigates power. Power is not seen as power over or empowering (giving power). Instead, mutual respect fosters space to remind us of the power every individual rightfully holds. It requires recognizing that we are dependent on each other and therefore power is shared (Bergum & Dossetor, 2005). Every team member has worth and his or her opinions would be valued. There are many activities to keep power in place and foster relationships such as listening, helping, being present, taking time to understand one another, communicating values and responsibility (Bergum & Dossetor, 2005; Peter & Liaschenko, 2013). This element of relational ethics has the potential to deepen our understanding of moral distress and potentially minimize these situations altogether.

***Engagement***

Ethical engagement between people in the healthcare environment needs intentional action and it is located in moments where people come together. Engagement cannot be possible without conversations. It requires the nurse to come to the relationship with a commitment to explore what is needed in this specific situation and for the patient to come with a desire to share (Bergum & Dossetor, 2005). Ethical engagement requires a relationship beyond a technical one (where the patient is seen as someone requiring care) and focuses on knowing the person and seeing them for who they are. These conversations are not only through verbal communication but also in touch, movement, silence, and written words. It is these conversations that allow trust

among strangers within healthcare relationships to develop. It allows strangers to begin to understand others' opinions, values, and situations (Bergum, 2004; Bergum & Dossetor, 2005). When there is engagement in a relationship, strangers can come together to make meaning out of tragic situations. Patients are willing to discuss their needs and nurses come with a commitment to explore the needs for that patient. Patients are no longer treated as objects in need of care and nurses are not seen as objects to fulfil patients' needs (Bergum, 2004). When we approach a patient as a component of the whole, the encounter becomes impersonal. The person is lost in their condition or symptoms (Bergum & Dossetor, 2005). Ethical engagement does not require more time. It requires being present, not thinking about other tasks or patients, but taking the time you are already spending with the patient and having a conversation. Ask them questions, hear what they have to say and listen for questions they are not asking or the fear in their voice.

Ethical engagement, in the context of relational ethics, offers a framework to better understand and possibly minimize some of the known contributors of moral distress. Treatment of patients as objects and poor relationships with patients and healthcare professionals are both documented as factors contributing to moral distress (Austin, 2012; Corley, 2002; Wilkinson, 1987). Consider a situation where the nurse and a patient disagree on starting a potentially life-saving treatment. Through engagement there is trust between the participants and open communication is possible. There is a deeper understanding of each individual's perspectives, values, and goals and a mutually satisfactory approach is taken. This does not mean there is mutual agreement but rather a deeper understanding of their choice. When true engagement occurs, patients are no longer objects, relationships develop between the nurse and patient, and nurses feel better equipped to handle tragic situations. Patients' identities are preserved, and the nurse's identity is also upheld by the patient (Peter et al., 2018) and nurses will not feel as though

they violated their own values. Genuine ethical engagement is not something that comes easily, and requires a great deal of practice, but when achieved it can allow both the nurse and the patient to be seen and therefore change our experiences that may otherwise be morally distressing.

### *Embodied Knowledge*

Embodiment focuses on knowledge generated from the mind, body and spirit. It gives equal weight to feelings and emotions as it does to physical signs and symptoms. Emotions are given value and embodied knowledge provides space for these to be meaningfully examined. Emotions provides a foundation for our mental and social lives and are part of embodied knowledge (Austin & Kunyk, 2011). This type of knowledge involves being present in our bodies, in relationships, and in the environment (Bergum & Dossetor, 2005). Embodied knowledge also acknowledges that people are passionate by nature and bodies hold experiences in their flesh and bones. It recognized that there is more to knowing than factual knowledge. This form of knowledge is lived in real time, subjective, and includes things that cannot be easily known (Bergum, 2004; Bergum & Dossetor, 2005). It includes the feeling of someone's flesh beneath your hand and becoming aware that it is not an object that is there but a person, one who you are sharing space and an experience with. Bergum and Dossetor (2005) state that if we treat a person as an object, there is a danger that all people become objects, and we will lose our capacity to be affected by and affect others.

Moral distress is not only dependent on the situation, but also on those involved in the situation. Each physical body that is present in a situation holds past experiences that are tied to feelings and emotions. Moral distress is a result of the dynamic interplay between this embodied knowledge, nurse's beliefs and the situation at hand. Factors contributing to moral distress,

encompassed in internal constraints, include a lack of courage and insecurity (Austin, Lemermeyer, et al., 2005) and these may be recognized and mitigated if embodied knowledge is valued. Applying the concept of embodied knowledge to potentially moral destressing situations could decrease the possibility of a nurse experiencing moral distress. This aspect of relational ethics looks at objectivity and subjectivity, thinking and feeling, as well as the self and others. This approach allows everyone involved in the situation to come together in spite of differences and describe how they are feeling and understand that this is a vital part of the lived experience (Bergum & Dossetor, 2005).

Increased sensitivity to morally distressing situations is one suggestion for dealing with moral distress. Austin and colleagues (2005) posit that if providers are better able to recognize his or her distress, and reflect upon situations that give rise to the distress, then this may increase ones' moral sensitivity and a "moral awakening" may occur (p.39). Through this awakening, nurses are better able to identify morally distressing situations, and this can be seen as a desired asset to increase one's moral sensitivity and therefore better prepare them for the situation at hand (Austin, Lemermeyer, et al., 2005). Valuing embodied knowledge can provide a foundation for understanding and increasing one's moral sensitivity. It requires nurses to be present in a given situation and acknowledge and learn from what she or he is feeling. Nurses need to not only think about what they are doing but how they are feeling or what they are thinking. This type of knowledge looks at the self, others, and the context. It requires valuing the lived experience that is necessary in this element of relational ethics.

### *Interdependent Environment*

The interdependent environment, within the relational ethics context, does not only include the physical environment in which healthcare occurs but also the environment of each situation within it. It is not seen as something beyond nurses or patients that can be manipulated, rather the environment needs to be understood relationally- where actions occur that affect and are affected by the whole system. The interdependent environment considers the environment as a living system enacted through each individuals' connection to one another. Through this lens, each individual act is important and therefore ethics is not only seen as social, political, or personal but also seen as part of a community of individuals working alongside one another (Bergum, 2004). Choices that are made in the practice environment, in moments between patients and nurses or other healthcare professionals, are impacted by the larger society. Societal views or values (for example the death of a child) will impact a single decision within the smaller environment of a particular situation. In just the same way, that situation and the decisions that come out of it, will cause a ripple effect and impact the those around them near and far.

Moral distress occurs within the healthcare environment and has been described as a nurse's response to constraints within the environment in which they work. This environment is under strain and has been labeled as a morally inhabitable place making it challenging for nurses to enact moral care (Austin, 2007). There are many environmental constraints described in the moral distress literature; they are categorized as external constraints. Examples of these include structural inequities, difficult working conditions, limited resources, inadequate staffing, lack of support, and working in isolation (Corley, 2002; Burston & Tuckett, 2013; Edwards et al., 2013; Huffman & Rittenmeyer, 2012; McCarthy & Deady, 2008; Prentice et al., 2016). These constraints limit nurses' abilities to act according to their morals, values, and beliefs, thus

contributing to potential morally distressing situations. The environment, large or small, impacts nurses work. An example of how the larger environment impacts a single nurse was eloquently demonstrated in a study by Wall and colleagues (2016) conducted in the pediatric intensive care unit. In the study, a nurse expressed anguish stating, “we’re supposed to save them, but we can’t save them all and saving has definitely different meanings to different people”.

If we look at the environment in a broader context then we recognize that it also includes our connections to one another, with patients and within our healthcare professional teams. We may start to recognize the impact that our actions and those of others around us have on the environment and understand that we are all connected. With this recognition maybe we will realize that we need to come together to support each other and make our environment a more habitable place. It is through collaboration and support that moral distress can be minimized (Lamiani et al., 2017).

**The Possibilities of Exploring Moral Distress Within a Relational Ethics Lens**

Relational ethics provides nurses with an action ethic that can be used in daily ethical interactions. It allows nurses to do the right thing for themselves as well as for others (Bergum, 2004; Bergum & Dossetor, 2005). The core elements of relational ethics have the potential to greatly impact the lives of nurses by increasing our understanding of moral distress and potentially reducing the occurrence of this phenomenon. By examining moral distress through a relational ethics lens, individuals recognize that when they come together in an ethically habitable environment, they are all connected. These individuals understand that they are creating an environment together, in real time, through interactions with one another. Trust is developed allowing those involved in the situation to speak more freely. Knowledge in the form of feelings and emotions that are held within one’s body are valued. Mutual respect is present,

and values, feelings, and beliefs of others are truly heard. Individuals are intentionally engaged in the moments where people come together.

It is important to note that exploring moral distress using the key elements of relational ethics will also help further nursing science. One way to do this is through education. Education is needed on relational ethics as well as moral distress. This education should extend beyond nurses because relational ethics and moral distress occur within the larger context of the health care environment (not just between one nurse and one patient). Education may also include the roles of other disciplines to enhance collaborative practice (McAndrew et al., 2018). This education may be included within the formal undergraduate education or it may be included in the educational program offered in the orientation to a specific unit.

Educational interventions within the research on moral distress are limited and the application of relational ethics to moral distress is even more sparse. There has been limited empirical work that explicitly approaches moral distress using relational ethics. It would be beneficial to develop educational interventions and test them within a particular context to see how (if at all) it affects moral distress within that environment. From there, this educational intervention can be adapted and utilized in other units or other populations.

Relational ethics is not something that should only be discussed. It has to be brought to life in practice. In practice it is important for the institution to be thought of as a moral community so space for ethical conversations is easier to create (Liaschenko & Peter, 2016). Policies need to be changed to ensure there is adequate space for all parties involved to state their views, have opinions, and be respected (Liaschenko & Peter, 2016). For the individual nurse (or other healthcare professional) to treat others with respect, ask deeper questions, truly listen to

others, and model the behaviour wanted in others. One small action will build into many small actions and these will turn into movements that will affect change.

Described above is a way to use relational ethics as a framework for asking innovative questions about moral distress and nursing practice. According to Risjord (2010), new nursing knowledge is obtained through the commitment nurses have to the advancement of nursing. New knowledge can thus be developed from real situations and real problems that nurses face in practice (Risjord, 2010). This approach allows for the development of new nursing theories to describe and explain phenomenon, which according to Meleis (2012) is the aim of nursing science.

**Conclusion**

Nurses need an ethic that better reflects their values as well as the complexities in day to day ethical situations. Relational ethics recognizes relational space as the location for moral encounters and considers ethics in every situation (Bergum, 2004). This ethic has the potential to serve as a guiding lens to advance our knowledge of moral distress. This is possible by examining these situations through the core elements of relational ethics: mutual respect, engagement, embodied knowledge, and interdependent environment. Relational ethics may be the answer needed to support nurses to act ethically in such a way that nurses' values are not violated. Relational ethics will not eliminate moral distress. There will be situations where agreement will not occur but this approach offers a step towards minimizing the devastating effects of moral distress.

Our next step to support ethical practice is to continue to further develop our knowledge of moral distress through this lens. No matter how we choose to advance nursing knowledge on this topic, new opportunities will be offered that will get us closer to better preparing nurses for

complex ethical situations in their everyday practice. New questions will be asked, and new nursing knowledge will inevitably be developed that will better support nurses and advance nursing practice.

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## Chapter 3 Paper 2: Navigating the Experiences of Moral Distress: A Scoping Review

**Abstract:**

**Background**: Moral distress is a complex ethical phenomenon that occurs when one is not able to act according to their moral judgement. Consequences of moral distress negatively impact nurses, patient care, and the healthcare system. There is limited evidence on specific approaches to prepare nurses to manage these ethical situations.

**Aim**: The aim of this scoping review was to identify moral distress interventions for nurses who provide direct patient care, identify gaps in the current moral distress research, and determine areas of focus for future research on this topic.

**Methods**: We employed the framework outlined by Levac, Colquhoun, and O'Brien and Arksey and O'Malley to conduct a scoping review. These steps included the: identification of the research question, identification of relevant studies, study selection, charting the data, collating, summarizing, and reporting the results. We appraised the quality of included studies using the Mixed Methods Appraisal Tool.

**Results**: We identified 5206 articles from the selected databases. Once duplicates were removed, two independent reviewers each screened 4043 title and abstracts. We included 554 articles for full-text screening, with 10 studies included based on inclusion and exclusion criteria. Study designs included before-after studies (n=4), randomized control trials (n=3), concurrent mixed-methods studies (n=2), and one controlled before-after study. All studies were conducted in acute care settings. In four studies, interventions focused on informing nurses on moral distress. Two interventions focused on increasing the nurses' reflexivity on their workplace experiences. One intervention included formal clinical mentoring and clinical ethics support through interprofessional rounds. Two studies utilized a multicomponent intervention. The overall moral

distress scores significantly decreased after intervention implementation in three included studies. Three additional studies showed significant differences in specific survey item scores (e.g., “provision of less-than-optimal care” and “caring for patients they did not feel qualified to care for”), as compared to overall scores, after intervention implementation. In 70% of studies the amount of quality criteria met were 60% or higher according to the Mixed Methods Appraisal Tool.

**Conclusion**: Our review is the first to synthesize intervention studies pertaining to moral distress among nurses. The findings of this review demonstrate that there is no clear pattern regarding which strategies consistently minimize the effects of moral distress among nurses. Future interventions should be tested more broadly by increasing the sample size, assessing length of intervention in relation to moral distress scores, expanding the interventions to other units and institutions, and including other healthcare professionals.

**Keywords:** Moral distress, scoping review, interventions, nurses

## Introduction

Nursing work environments are becoming more complicated due to increased acuity of patients, advances in technology, pressures to maintain minimum practice standards, and accountability to their employer to minimize health care costs (Austin, 2012; Austin, Lemermeyer, et al., 2005; Corley, et al., 2005; Wall, et al., 2015). These environments influence nurses' ability to work effectively and can lead to ethical challenges including moral distress (Austin, 2016; Sasso, et al., 2016). The plethora of research on moral distress has identified its profound negative effects on nurses, patient care delivery, and the health care system itself (Epstein, et al., 2020; Morley, et al., 2020; Whitehead et al., 2015).

Numerous unique definitions have been used to describe moral distress, although these variations overlap in meaning are derived from generally the same sources (Deschenes, et al., 2020). Moral distress occurs when there is a conflict between the ethically correct action and what the nurse is required or capable of doing. For the purposes of this review, we adopted Jameton's expanded definition of moral distress (1993). Moral distress includes initial and reactive distress (Jameton, 1993). Initial distress includes feelings of frustration, anger and anxiety one may experience when they are faced with institutional or personal constraints that impede them from doing what they believe is right. Reactive distress is experienced if an individual does not act on their initial distress (Jameton, 1993). Moral distress does not occur due to a specific situation but rather in combination with a nurse's values, making morally distressing situations unique for each individual (Austin, et al., 2003; Burston & Tuckett, 2013). Factors contributing to moral distress have been categorized as internal (e.g. fear, lack of knowledge) and external (e.g. interprofessional relationships, limited resources) (Austin, 2012; Austin, 2016; Corley, et al., 2005; McCarthy & Deady, 2008; McCarthy & Gastmans, 2015). Moral distress

can lead to deleterious physical, emotional, behavioural, and spiritual responses such as anxiety, depression, guilt and burnout (Austin, Rankel, et al., 2005; Austin, 2012; Dryden-Palmer et al., 2018; Epstein, et al., 2020; Rushton et al., 2016).

Nurses, due to their position in the health care system and their relationship with patients, are especially prone to developing moral distress and may experience an increase in intensity of the phenomenon when compared to other healthcare professionals (Austin, Lemermeyer, et al., 2005; Larson, et al., 2017; Whitehead et al., 2015). Nurses are closely involved in patients' care, providing close bedside attention when the patient is most vulnerable and must support patients who are facing moral challenges themselves. They are constantly surrounded by ethical issues, whether they are aware of this or not (Austin, Lemermeyer, et al., 2005). Nurses have to take into account their own beliefs, those of the patients, as well as the constraints of the environment that they work in, in every situation.

The effects of moral distress extend beyond the individual nurse to impact patient care as well as the health care system (DeKeyser Ganz & Berkovitz, 2012; Epstein et al., 2020; Wilkinson, 1987). The effects moral distress has on the individual nurse can lead to ineffective coping strategies such as the nurse to avoid patients altogether (Morley, et al., 2020). This can lead to poor quality patient care and decreased patient satisfaction (Dekeyser, Granz, & Berkavitz, 2012; Burston, & Tuckett, 2012). Furthermore, moral distress is a significant contributor to low retention and high turnover among nurses (Bong, 2019; Waillis, 2015), resulting in up to 45% of nurses reporting their intent to leave or having left their position (Austin, et al., 2017; Nathaniel, 2006). It is critical that we move beyond describing moral distress to developing strategies to minimize the effects of moral distress, and both individual specific and organizational level interventions are needed (Burston & Tuckett, 2013; Dryden-

Palmer, et al., 2020). The purpose of this scoping review is to comprehensively identify moral distress interventions for direct patient care nurses. In this review, we will map out the existing interventional studies on moral distress, identify gaps in the existing body of knowledge, and determine areas for future research on this topic.

## Methods

### *Study Design*

A scoping review, as outlined by Levac, Colquhoun, and O'Brien (2010) and Arksey and O'Malley (2005), was chosen because we aimed to identify the nature, extent, and range of research evidence in this field by mapping out the existing research on this topic (Grant & Booth, 2009; Schick-Makaroff, et al., 2016). The steps of this review included the: identification of the research question, identification of relevant studies, study selection, charting the data, collating, summarizing, and reporting the results (Levac et al., 2010).

### *Search Strategy*

The electronic literature search strategy for identifying all relevant studies was developed with the assistance of a research librarian. Search terms included morality, moral injury, occupational stress, resilience, psychological stress, or burnout AND moral, ethics, distress*, stress*, or responsibility*, dilemma*, or conscience* AND nurs*. The search included four electronic databases Ebsco CINAHL Plus full text, Ovid EMBASE, Ovid Medline, and PsycInfo from 1984 to February 2020. In addition to searches of relevant databases, reference lists of included articles were hand-searched for any additional references that met inclusion criteria. Due to study feasibility (resource and time limitations) grey literature was not searched.

### *Inclusion/exclusion Criteria*

We included articles if they met the following criteria: 1) interventional studies on moral distress, 2) participants were nurses working directly with patients or participants included nurses and a sub-analysis by professional group/role was conducted, and 3) moral distress was clearly defined by the researchers, and the definition included the main components of moral distress. These components are that the nurse knows the right thing to do, is unable to act accordingly, and experiences some residual distress from the situation. Moral distress can be conflated with other terms such as 'moral dilemma' and therefore, an explicit definition of moral distress was required for study inclusion.

We excluded articles if they were non-interventional articles such as editorials, commentaries, methodological papers, book chapters, conference abstracts, protocols, reviews, discussion, or opinion papers. Doctoral dissertations were excluded if they were not published in an academic, peer-reviewed journal. Additionally, we excluded articles if research participants did not provide direct patient care (e.g., nurse managers, clinical nurse educators, nurses in management positions, etc.). We restricted articles to English only, due to resource restrictions, and those published after 1984 because this is when Andrew Jameton first defined the concept of moral distress (Jameton, 1984). We conducted quality assessments to describe the level of quality of included articles. However, we did not exclude articles based on the outcome of the quality assessment.

### *Screening Procedures*

We used EndNote© to manage all screening stages. Research team members met at the beginning of the screening process to discuss inclusion and exclusion criteria. We completed all levels of screening independently by two reviewers (SD, KT). An initial 10 titles/abstracts were

screened and reviewers met to ensure a unified understanding of the inclusion to exclusion criteria and assess the level of agreement between reviewers. At this time, adjustments were made to exclude studies examining the validation of moral distress measurement tools or testing the psychometric properties of these tools. Next, all articles included for full-text screening were read in full and screened based on eligibility criteria defined a priori and categorized as "include" or "exclude." Each reviewer completed the screening tool for all articles included for full-text screening. The review team met after 10 articles were screened to reflect on the process and refine as needed.

### *Data Extraction*

One team member (SD) independently extracted data from the included studies using a customized data extraction table, and a second reviewer (KT) verified all data extracted. Data extraction elements included: 1) study characteristics including year, country, research question, and objectives; 2) study design (as per Hartling et al., 2011), theoretical framework, setting, sample/population; 3) description of the intervention; 4) intervention details including the kind of intervention, the role of the care provider, and the intervention frequency, duration and timing, 5) timing of data collection and measurement tools used, and 6) type of data analysis used, results, and recommendations for future research. For consistency, study designs for all included studies were determined using the classification tool developed by Hartling and colleagues (2011).

### *Data Analysis and Synthesis*

The extracted data were collated and summarized in the form of descriptive numerical summary and qualitative thematic analysis. Data synthesis examined commonalities and differences in terms of methods, location, and findings. Focus was paid to details surrounding the intervention, as well as the recommendations identified to mitigate and resolve moral distress for

nurses. Gaps in the moral distress literature are identified as are author recommendations on where to focus further research efforts.

### *Quality Appraisal*

Quality assessment was conducted for all included studies using the Mixed Methods Appraisal Tool version 2018 (Hong et al., 2018). This tool has been validated for studies with diverse designs (Souto et al., 2015) and allows evaluation of studies with different methodological designs using the same tool. The Mixed Method Appraisal Tool 2018 version addresses five categories of studies: qualitative, quantitative randomized controlled trials, quantitative non-randomized, quantitative descriptive, and mixed methods (Hong et al., 2018). This tool includes two initial screening questions pertaining to the research question, followed by five quality scoring criteria regarding sampling, data collection, and analysis for each study design (Hong et al., 2018). The use of this tool provided a consistent perspective across all study designs that could not have occurred using unrelated tools to assess articles with different designs. Although we evaluated the quality of included studies in this review, studies were not excluded based on the quality assessment outcome. This step allowed us to address the level of quality of included studies. Two reviewers (SD and KT) independently completed quality appraisal for all included studies.

## Results

There were 5206 articles identified from selected databases. Once duplicates were removed, 4043 were included for first-level screening and 554 articles were included in the second-level screening. Ten articles, which included 524 nurses, met all inclusion and exclusion criteria so were included in this review (Figure 1). Included studies were published between 2008-2020. Study designs included before-after studies (n=4), randomized control trials (n=3),

concurrent mixed-methods studies (n=2), and one controlled before-after study. Countries where the study was conducted include United States (n=4), Iran (n= 3), Canada (n=1), and two studies did not report the country. All studies were conducted in acute care settings; critical care (n=5), adult med/surg (n=3), pediatrics (n=1), and not specified (n=1). (Table 1).

### *Quality appraisal*

All ten studies were assessed using the MMAT version 2018 (Hong et al., 2018). Table 3 provides details of each criterion to informing the quality of the included studies. Overall, the methodological quality of included studies varied and all studies had methodological limitations. In the quantitative randomized control trials the outcome assessors were not blinded in any of the included studies. However, strengths of these studies included appropriate randomization and comparability of participant groups. Across the majority of quantitative non-randomized and mixed method studies, cofounders were not specifically accounted for in design and analysis. General strengths of these studies included fidelity of the interventions and appropriateness of measures used. The distribution of scores varied (Table 3) with the majority of the studies (n=7, 70%) having met 60% or higher of the Mixed Methods Appraisal Tool quality criteria. These designs overall cannot support firm conclusions around which interventions are more successful than others or make causal claims around the interventions' effects on moral distress.

### *Types of Intervention*

Intervention foci included: 1) moral distress awareness and information, 2) nurses workplace reflexivity, 3) interprofessional rounds, 4) policy change, and 5) multicomponent intervention. Four studies implemented interventions that informed participants on moral distress (Abbasi, et al., 2019; Beumer, 2008; Bevan & Emerson, 2020; and Molazem, et al., 2013). Two of these studies (Beumer, 2008; Molazem, et al, 2013) provided educational workshops on moral

distress based on the *American Association of Critical-Care Nurses* (AACN) model "The 4A's to Rise Above Moral Distress" (AACN, 2005). In both of these studies, the workshops provided information on moral distress, including symptoms, complications, and coping strategies of the phenomenon. In Beumer's (2008) study, intensive care unit nurses were encouraged to develop a plan of action to improve their well-being. This workshop consisted of a single 2-hour session that was offered over four weeks. Whereas in Molazem and colleagues' (2013) study, cardiac care nurses were required to work in groups to discuss morally distressing situations and strategies one could implement in these situations. This workshop was provided over 2, 4-hour session. One study that implemented an intervention directly on moral distress developed a moral empowerment program for adult intensive care unit nurses (Abbasi et al., 2019). This program was based on Nathaniel's theory of moral reckoning (Nathaniel, 2006) and included two 6-hour sessions. In the program, moral distress was discussed, including adverse effects and strategies to overcome these effects. The program also included group work to discuss personal experiences of moral distress in the form of a story and then applied learned strategies to the stories. At the end of the program, nurses were provided with pamphlets outlining these strategies for dealing with moral distress. The last study developed a Freirean-based conscientization intervention directly on moral distress (Bevan & Emerson, 2020). This intervention included 3, 4-hour sessions each aligning with one of the three phases of Freire's pedagogy: critical reflection, critical motivation, and critical action (Freire, 1995). The sessions included activities such as nurses examining their experiences of moral distress, identifying the relationship between their experiences and power dynamics, drafting an action project, and describing change can occur from developing skills (Bevan & Emerson, 2020).

Two studies developed interventions that focused on increasing the nurses' reflexivity on their workplace experiences (Meziane, et al., 2018; Saeedi, et al., 2019). One intervention included an educational session on narrative writing and asked nurses (working in medical/surgical, obstetrics/gynecology, and intensive care units) to write their thoughts and emotions related to the tensions, including moral experiences, at their work (Saeedi, et al., 2019). Researchers asked participants to write about their experiences at least once a week for eight weeks. Similarly, Meziane, et al. (2018) implemented a reflective practice intervention with bedside nurses that focused on significant end-of-life situations that the participants experienced. The goal was to reflect on these situations and raise awareness of the contradictions between ideal care and reality. This intervention was conducted over 3 group sessions, each lasting between 45-75 minutes (Meziane, et al., 2018) and was based on Watson's concept of human caring (2012) and Johns' model for structured reflection (2006).

One intervention, implemented in a children's hospital, included formal clinical mentoring and formal clinical ethics support through interprofessional rounds (Wocial, et al., 2017). Rounds were conducted weekly for 12 months. This intervention was designed to facilitate discussion about care goals and ethical issues in children and clarify treatment goals for each patient discussed. Another study implemented a single policy change within an inpatient adult unit, which provided nurses with the opportunity to consult palliative care directly and examined the effects this change had on the nurse-participant levels of moral distress (Bosshardt, et al., 2018).

Most of the studies (n=8) focused on the implementation of a single-modal intervention (as discussed above), while two studies utilized a multicomponent intervention to address moral distress (Bruce & Allen, 2020; Vaclavik, et al., 2018). Bruce and Allen, (2020) implemented a

three-pronged intervention within a medical-surgical oncology inpatient unit, which included debriefing sessions at least four times a year, and communication skills building. Additionally, communication resources were provided to all nurses who attended the *End of Life Nursing Education Consortium's Oncology* conference. While Vaclavik and colleagues (2018) implemented a multicomponent intervention within an adult inpatient hematology/oncology unit. The intervention included clinical debriefing sessions that occurred within 48 hours after a significant event, "code lavender bags" as stress relief resources for nurses on the unit who requested one, a "tree of life" displayed on the breakroom wall to celebrate the lives of patients' who have died, a work-life balance committee who planned four social events in the first six months of the study, yoga classes that were implemented twice a week, and mindfulness sessions offered daily for six weeks then every Monday morning after that.

Of the included interventions, the majority (n=8) solely focused on changes for the individual nurse (e.g., increase reflexivity, develop coping strategies, increase knowledge and awareness of moral distress, etc.), one intervention focused on changes among the individual as well as changes within the unit (Vaclavik et al., 2018). One intervention solely focused on a unit-based change (Bosshardt, et al., 2018).

### *Intervention Providers and Recipients*

Participants in most of the studies (n=9) were solely registered nurses. In one study (Wocial, et al., 2017), participants included a multidisciplinary team, but only data pertaining to nurse participants were extracted. Nurse participants in all studies worked in an acute care setting.

In the majority of the studies (n=5), a combination of experts in various fields provided the intervention: nurse manager, counselor and clinical nurse specialist (Beumer, 2008); senior

intensivist and an ethicist (Wocial et al., 2017); nurse researchers, an ethics specialist and a psychiatric nursing specialist (Abbasi, et al., 2019); hospital chaplain, clinical nurse specialist, and nurses (Bruce & Allen, 2020); grief counselor, nurses specifically trained in yoga, psychosocial oncology director with training in mindfulness-based stress reduction, and the unit leadership team (Vaclavic et al., 2018) (Table 2). In one study, nurse researchers alone provided the intervention (Meziane, et al., 2018). The intervention provider was not reported in four of the included studies (Bevan & Emerson, 2020; Bosshardt, et al., 2018; Molazem, et al., 2013; Saeedi, et al., 2019).

***Intervention Measurement Tools and Timing of Data Collection***

Most of the included studies (n=7) used the *Moral Distress Scale-Revised* (Hamric et al., 2012) to measure moral distress levels. This tool consists of 21 items that ask respondents to rate their moral distress level and accounts for both the frequency and intensity of moral distress (Hamic et al., 2012). This tool has been validated in many settings, including adult and pediatric acute care units (Hamric et al., 2012; Whitehead et al., 2015). Two of the included articles used Corley and colleagues' (2001) *Moral Distress Scale*, one of which was the Persian version (Nafchi et al., 2015). This tool consists of 32 items and has been assessed for reliability and validity in Iran's nursing community (Merghati Khoiee, et al., 2008). One study based their questionnaire on Corley's *Moral Distress Scale* rather than using the tool itself. The final study used the *Moral Distress Thermometer* (Wocial & Weaver, 2013) in addition to the *Moral Distress Scale- Revised*. The *Moral Distress Thermometer* was designed to measure acute moral distress and is useful for rapid measurement of moral distress (Wocial & Weaver, 2013).

All studies collected data before and after the moral distress intervention. Data collection after the intervention ranged from immediately after to up to 12 months after the intervention. In

one study, the *Moral Distress Thermometer* and the *Moral Distress Scale- Revised* were used to measure moral distress. The *Moral Distress Thermometer* was administered monthly to measure acute moral distress, whereas the *Moral Distress Scale- Revised* was administered pre-intervention and 12 months post-intervention to measure chronic moral distress among participants (Wocial, et al., 2017). Two of the randomized control trials (Abbasi et al., 2019; Molazem, et al., 2013) collected data at two separate time intervals after the intervention: two weeks as well as one month after the intervention, and 1 and 2 months after the intervention respectively. Two studies did not provide specific details about the timing of data collection; they only stated data were collected before and after the intervention (Bevan & Emerson, 2020; Saeedi, et al., 2019).

***Intervention Outcomes***

Three studies reported statistically significant decreases in overall moral distress scores after exposure to the intervention. Abbasi and colleagues (2019) reported a statistically significant decrease in the mean *Moral Distress Scale- Revised* score preintervention compared to one month after the intervention but not when comparing preintervention to two weeks after the intervention. Molazem et al. (2013) noted a statistically significant decrease in the mean *Moral Distress Scale* scores in the intervention group prior to the intervention and one and two months after, as well as comparing the intervention group with the control group. Bevan and Emerson (2020) noted a statistically significant decrease in means of overall moral distress as well as in the frequency subscale when comparing scores pre intervention to post intervention. However, they found a statistically significant increase in the intensity subscale (Bevan & Emerson, 2020).

Three studies found statistically significant differences in specific survey items but noted no significant difference in overall moral distress scores. Vaclavik et al. (2018) observed a significant decrease in survey item "frequency with which staff nurses felt distressed from observing healthcare providers give a false sense of hope to patients" when comparing pre-intervention scores to post-intervention scores. Bosshardt and colleagues (2018) noted a statistically significant increase in three *Moral Distress Scale- Revised* survey items when comparing pre-intervention to post-intervention scores: "provision of less-than-optimal care"; "caring for patients they did not feel qualified to care for"; and "working with other health care providers who were not competent to care for the patient. A statistically significant decrease in *Moral Distress Scale- Revised* item "continuation of care for a hopelessly ill patient" was found (Bosshardt, et al., 2018). Although not statistically significant, Bosshardt and colleagues (2019) also found an increase in nurses wanting to leave their position after the intervention. Prior to the intervention, 49.5% of participants considered leaving their current or previous position compared to 55.1% after the intervention. Whereas 22% of nurses were actively considering leaving their position before the intervention compared to 30.8% afterwards.

Wocial et al. (2017) found a statistically significant improvement when comparing matched pairs in three items on the *Moral Distress Scale- Revised*. These included "initiate extensive life-saving actions when I think they only prolong death," "work with nurses or other healthcare providers who are not as competent as the patient care requires," and "witness diminished patient care quality due to poor team communication." In the intervention group there was a statistically significant decrease in the length of stay, a statistically significant increase in code status changes to do not resuscitate, yet no difference was noted in 30 or 365 day-mortality rate (Wocial, et al., 2017). Additionally, 85.5% of nurses noted an overall improvement in their

ability to communicate with other healthcare professionals, and 88.2% reported an improvement with patients and their families. In three studies, no statistically significant results were noted (Bruce & Allen, 2020; Meziane, et al., 2018; Saeedi, et al., 2019).

One study (Beumer, 2008) stated that their intervention decreased the nurses' experience of moral distress; however, it was unclear whether this was statistically significant. Notably, 12% of the intervention group said they 'strongly agreed' with having adequate resources to cope with moral distress pre- intervention compared to 23% post-intervention. Nurses' 'strongly agreeing' that their opinion was valued increased from 4% pre-workshop to 14% post-workshop with 28% "agreeing" pre-workshop and 33% post-workshop. However, the control group had a similar response in these categories. Feeling negative or cynical about patients' care decreased after the intervention with a change from 75% of nurses feeling this way to 28% post-intervention (control group reported 42%) (Beumer, 2008).

Two mixed-methods studies were included in this review (Bevan & Emerson, 2020; Bosshardt et al., 2019). In Bevan and Emerson (2020) the qualitative component consisted of participants' written stories on moral distress, audio recordings from the discussions, diagramming exercises, worksheets, and semistructured individual interviews. Four themes were identified including 'sources of moral distress', 'responses of the nurses', 'power dynamics' and 'lack of resolution'. The qualitative component from Bosshardt and colleagues' study (2019) consisted of adding a free-text comment section to the *Moral Distress Scale- Revised* and conducted qualitative thematic analysis on the responses. Four themes contributing to nurses' moral distress were noted: inadequate staffing, communication, ethical concerns, and lack of education.

There is no clear pattern on which intervention consistently minimizes the effects of moral distress among nurses. However, the three studies that noted a statistically significant decrease in overall moral distress scores provided at least two sessions lasting either 4 or 6 hours for each session (Abbasi, et al., 2019; Bevan & Emerson, 2020; Molazem, et al., 2013).

### *Recommendations from Included Studies*

The majority of included studies (n=9) had recommendations for future research. Several recommendations were related to testing the intervention more broadly, including increasing sample size, expanding interventions to other units, including other healthcare professionals in the intervention, and testing interventions in different institutions (Abbasi, et al., 2019; Bevan & Emerson, 2020; Meziane, et al., 2018; Molazem, et al., 2013; Vaclavik, et al., 2018). Other recommendations included studying the effects of narrative writing on positive events (Saeedi, et al., 2019), considering the root causes of moral distress to resolve the distress (Meziane, et al., 2018), identify and utilize mechanisms to control moral distress (Molazem, et al., 2013), management implementing empowerment programs within hospital units (Abbasi, et al., 2019), developing a concise and reliable tool to measure moral distress (Beumer, 2008); and determining the effectiveness of strategies to manage moral distress (Vaclavik, et al., 2018). Wocial and colleagues (2017) state that measuring levels of moral distress immediately before and after their weekly intervention might prove more useful than waiting until the end of the study period to measure levels of moral distress. The researchers also state that asking participants to identify their level of moral distress related to specific patients' treatment plans, rather than overall moral distress, would prove to be more useful (Wocial, et al., 2017).

**Discussion**

In this review, we identified ten interventional studies designed to mitigate the effects of moral distress for nurses providing direct patient care. Interventions in this review (n=7, 70%) were implemented to evoke a change in the individual nurse. One study implemented an intervention that included both nurse and unit focused components (Vaclavik, et al., 2018). Another study implemented a unit policy change and examined the effects this change had on nurses' moral distress (Bosshardt, et al., 2018), thereby examining an intervention focused on systemic change. In their recommendations for future research, Meziane, et al. (2018) state that more research should examine the root causes of moral distress to attempt to resolve the distress as opposed to strategies aimed at managing the responses to moral distress. However, tension exists within the literature about the root cause of moral distress. Some state that the root cause of moral distress is the individual and their response to the situation, while others state the root cause is the system in which the phenomenon occurs and subsequently, tension exists on where to focus interventions. We are organizing the discussion following the central themes in our synthesis: 1) level of intervention focus, 2) measurement tools for moral distress, and 3) the infrequency of patient outcomes reported in moral distress interventions.

First, interventions focusing on changes related to the individual could reflect or imply personal failings or even a lack of competence of the nurse (Lutzen & Kvist, 2012; McCarthy & Deady, 2008; Varcoe et al., 2012). Austin (2016) states that because moral distress is not experienced within a vacuum but within an environment that plays a role in its development, the focus for mitigating its impact ought to be placed on systemic changes. Moreover, as moral distress is a product of external constraints within the organization, a shift of focus from the individual to the organization is required to make the environment more morally sensitive (Lutzen & Kvist, 2012).

Specifically, leaders should provide opportunities for staff to communicate their moral distress and share experiences, as well as focus on institution-based ethical policies such as policies that guide practice around goals of care (Bell & Breslin, 2008; Bong, 2019; Pendry, 2007). Pendry (2007) suggests that worksite interventional programs should focus on areas most prone to the effects of moral distress (such as critical care units) to have a more significant impact on effecting change. Initiatives should start by focusing on unit-based changes; however, for lasting change, system-wide initiatives must be considered (Bong, 2019). Additionally, accounts of moral distress may be similar in many ways internationally (e.g., feelings of powerlessness, limited autonomy etc.) yet important differences in causes of moral distress may occur due to the sociocultural context of a particular healthcare system therefor it is important for leaders to take these differences into account when considering interventions (Ulrich et al., 2018).

Alternatively, a recent national survey examining the moral distress of different healthcare providers within pediatric and neonatal intensive care units across Canada found little variation of moral distress scores attributed to intensive care units (microsystems), hospitals (meso), and regions (macro) (Dryden-Palmer, et al., 2020). Rather, in their model, Dryden-Palmer et al. (2020) found that the majority (94.5%) of unexplained variance was due to differences between the individuals experiencing moral distress. In light of these findings, the researchers recommended that future interventions be tailored to the individual but target units where moral distress is high, such as critical care settings (Dryden-Palmer, et al., 2020). Rushton (2016) states that the current narrative of 'disempowerment, despair and hopelessness' that surrounds moral distress can contribute to 'a culture that undermines lasting and meaningful results.' Rushton (2016) proposes that building moral resilience among nurses is the way forward

to address the pervasiveness of moral distress. By increasing one's moral resilience, nurses will be able to navigate the inevitable and unpredictable challenges in a way that aligns with their values and maintain their integrity even when their preferred outcome is not achieved (Rushton, et al., 2016). This approach changes the narrative of moral distress, moving from victimhood towards empowerment and enables the nurse to recognize the experience as an indicator of moral conscientiousness instead of moral failure (Rushton, et al., 2016). Rushton and colleagues (2016) further state that cognitive, emotional, and behavioural approaches could be useful to build moral resilience, not unlike the interventions found in this review.

Due to the limited interventional studies on moral distress, we encourage researchers to continue to develop interventions at both individual and organizational levels. Individual approaches aimed at enhancing nurses' ability to manage ethically difficult situations, by increasing nurses' moral resilience, are necessary to empower nurses. It has been recommended that future studies be explored in areas with high levels of moral distress (Dryden-Palmer, et al., 2020; Pendry, 2007); however, all interventional studies in this review have been conducted in acute care settings. Future studies should also explore interventions in other areas, such as long-term care. The level of COVID-19 cases during the global pandemic suggests that moral distress interventions will be needed in long-term care settings. Additionally, given the complexity of moral distress, robust designs that examine intervention effectiveness within real life practice settings, such as pragmatic trials, warrant further exploration (Patsopoulos, 2011).

Second, in this review, three different validated moral distress tools were used to examine the efficacy of interventions to minimize moral distress among nurses. These tools include Corley's *Moral Distress Scale*, Hamric's *Moral Distress Scale- Revised*, and the MDT. Only one included study did not use a validated instrument, and this study also recommended that a

concise and reliable tool be developed to measure moral distress (Beumer, 2008). Since that time, a systematic review assessed and evaluated six unique moral distress instruments. The researchers found that Corley's instrument or instruments derived from this tool (including *Moral Distress Scale- Revised*) is the most useful instrument for practice and research, based on internal consistency and structural validity (Giannetta, et al., 2020). In our review, the majority of included studies used Corley's *Moral Distress Scale* (n=2) or the *Moral Distress Scale-Revised* (n=7) which is derived from the *Moral Distress Scale*. Giannetta et al., (2020) also stated that Wocial and Weaver's *Moral Distress Thermometer* was the only instrument that measured real-time moral distress. Of the seven included studies that used the *Moral Distress Scale-Revised*, different metrics were reported, making a comparison between interventions and the resulting moral distress scores difficult. Standardized reporting of *Moral Distress Scale- Revised* scores would be beneficial to compare results.

Third, our findings highlighted that most studies do not report the effects of the intervention on patient care, highlighting a gap in the potential outcomes of moral distress interventions. Wocial et al. (2017) found a statistically significant decrease in pediatric intensive care unit length of stay and an increase in code status change to "do not resuscitate" between patients in the intervention compared to the control group, affirming that moral distress affects patient outcomes. The researchers propose that these changes resulted from more proactive conversations among the healthcare team and with families (Wocial et al., 2017). Hamric and Blackhall, (2007) found that nurses who had higher levels of moral distress also had a lower perception of quality of patient care. Similarly, Burston & Tuckett (2012) found that nurses avoided patients due to moral distress and subsequently felt they were not providing quality patient care. Maiden et al., (2011) found a correlation between higher levels of moral distress and

an increased perception of medication errors. However, these studies did not directly measure the effects on patient care. Therefore, we recommend that researchers consider the impact that moral distress interventions have on patient outcomes (such as length of hospital stay, perceived quality of care, missed care, etc.) and further explore this relationship. Given that the three studies that noted a statistically significant decrease in overall moral distress scores provided at least two sessions lasting either 4 or 6 hours for each session, future research should also examine if the length of the intervention affects nurses' moral distress.

**Limitations**

Our study is limited due to restricting inclusion to studies cited in academic journals. Other limitations include low methodological quality of the included studies and including studies only published in English.

**Conclusion**

Despite the prevalence of moral distress in nursing clinical environments and increasing focus in research there are few studies that identify moral distress interventions for nurses who provide direct patient care. Our review is the first to synthesize intervention studies. The findings of this review demonstrate that there is no clear pattern regarding which strategies best minimize the effects of moral distress among nurses. The three studies that noted a statistically significant decrease in overall moral distress scores provided at least two sessions lasting either 4 or 6 hours for each session, tentatively suggesting that longer interventions may have a greater impact on decreasing moral distress among nurses. Future interventions should be tested more broadly by increasing the sample size, expanding the interventions to other units, including other healthcare professionals, and testing interventions in different institutions. Developing a standardized way to report the findings from the Moral Distress Scale- Revised would be beneficial as it would

allow researchers to make comparisons between studies that use this measurement tool. Future studies are warranted to explore the effect of the has intervention on patient outcomes.

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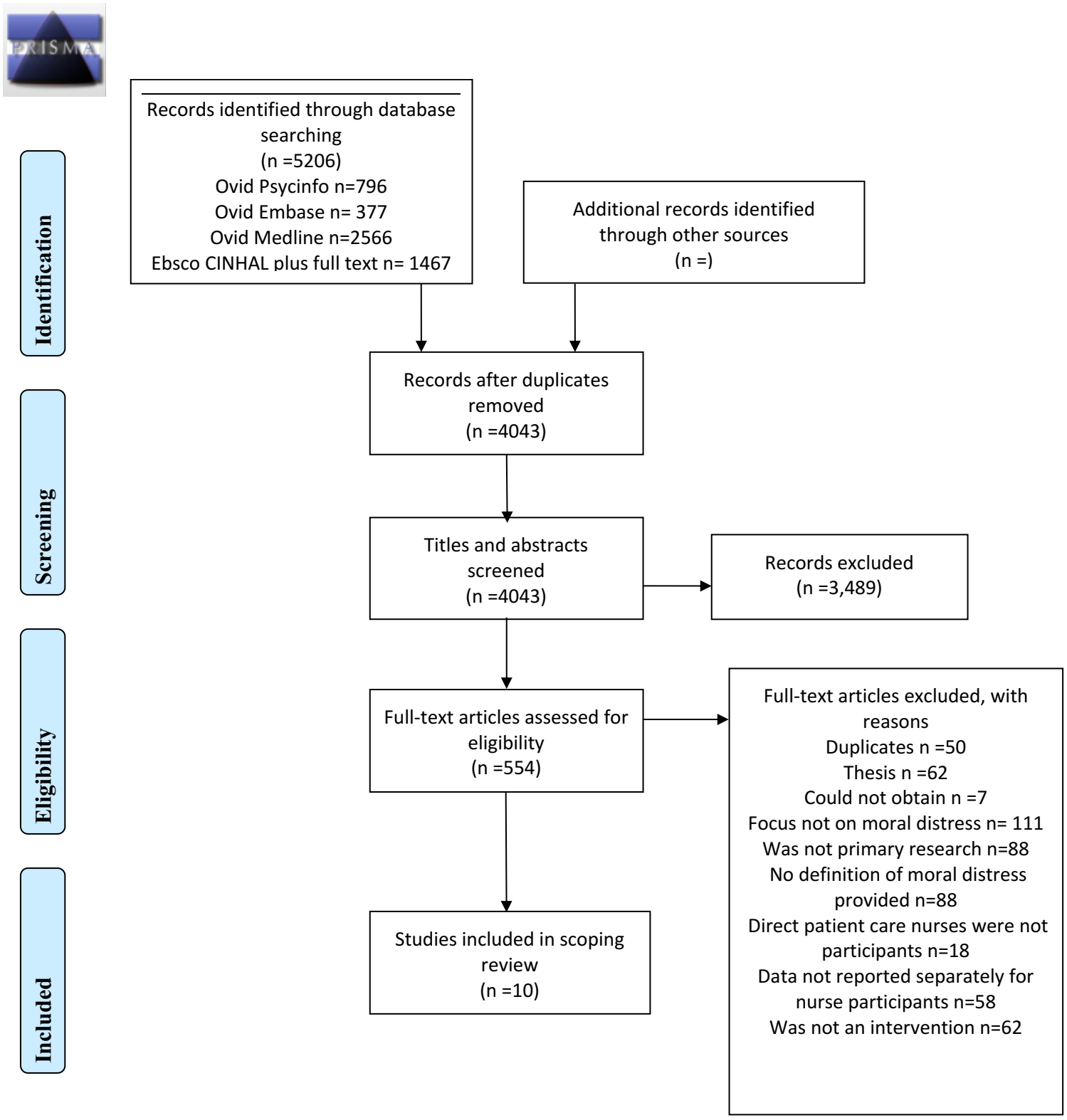


*Figure 3-1* **PRISMA flow diagram outline**

**Table 3-1 Characteristics table**

| First Author (year), country | Research Design | Setting (Sample size) | Moral distress measurement tool |
|---|---|---|---|
| Abbasi (2019) Iran | Randomized control trial | Adult intensive care unit Medical Sciences (n= 30 intervention group, n=30 control group) | Moral Distress Scale–Revised (Hamric et al., 2012). |
| Beumer (2008) USA | Controlled before-after study | Intensive care unit for intervention group, Float pool for control group (nurses who regularly worked in the intensive care unit (n=21 intervention group, n= 13 control group) | Questionnaire with themes based on Corley's Moral Distress Scale. 8 questions using a 5-point Likert scale, 4 true/false statements. |
| Bevan (2020) USA | Concurrent mixed methods design | Critical care nurses from a large metropolitan area (n=13) | Moral Distress Scale–Revised (Hamric et al., 2012). |
| Bosshardt (2018) USA | Concurrent mixed methods design | Medical center (n= not reported) | Moral Distress Scale–Revised (Hamric et al., 2012). An additional free-text comments section was added. |
| Bruce (2020) USA | Before-after study | Medical-surgical oncology inpatient unit (n= 55 preintervention, n= 17 post intervention) | Moral Distress Scale–Revised (Hamric et al., 2012). |
| Meziane (2018) Canada | Before-after study | University hospital center (n=19) | Moral Distress Scale–Revised (Hamric et al., 2012). |
| Molazem (2013) Iran | Randomized control trial | Cardiac Care Unit (n= 30 intervention group, n=30 control group) | Moral Distress Scale (Corley et al., 2001). Reliability and validity assed in Iranian nursing population (Merghati Khoiee et al., 2008) |
| Saeedi (2019) Iran | Randomized control trial | Medical surgical units, obstetrics and gynecology units, and intensive care units (n= 60 intervention group, n= 60 control group) | Persian version of Corleys Moral Distress Questionnaire (validity and reliability already confirmed in Iranian population Nafchi et al., 2015) |
| Vaclavik (2018) USA | Before-after study | Adult inpatient hematology/oncology unit (n=28 pre-intervention, n=18 post-intervention) | Moral Distress Scale–Revised (Hamric et al., 2012). |
| Wocial (2017) USA | Before-after study | Quaternary children's hospital (n=79 pre-intervention, n=53 nurses post intervention, including n=32 matched pairs) | Moral Distress Scale–Revised (Hamric et al., 2012). Moral Distress Thermometer (Wocial & Weaver, 2013). |

**Table 3-2 Interventions table**

| Studies | Intervention | Single intervention (S) or multi (M) | Deliverer of intervention | Frequency | Duration | Overall statistical significance | In no over all statistical significance, Individual Items on the measurement tool were statistically significant |
|---|---|---|---|---|---|---|---|
| Before-After Studies | | | | | | | |
| Bruce, 2020 | Debriefing, communication skills building, communication resources | M | Hospital chaplain, clinical nurse specialist, nurse-led | Debriefing sessions quarterly or PRN | Not reported One-time event for handouts | No | No |
| Meziane, 2018 | Reflective practice | S | Nurse researcher | 3 group sessions, one every 2-3 weeks | 45-75 minutes each session | No | No |
| Vaclavik, 2018 | Mindfulness bundle including critical debriefing, code lavender bags, tree of life created to celebrate patients' lives, work-life balance committee to plan networking events, yoga classes, and mindfulness sessions. | M | Grief counselor, specially trained nurse, physician trained in MBSR, leadership team | Debriefing within 48 hours, yoga twice a week, daily mindfulness sessions for 6 weeks, then weekly | Mindfulness : 10 minutes | No | Yes |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Wocial, 2017 | Interdisciplinary clinical ethics rounds | S | Senior intensivist and ethicist | Weekly | 12 months | No | Yes |
| Randomized Control Trials | | | | | | | |
| Abbasi, 2019 | Empowerment program | S | Researcher, medical ethics specialist, psychiatric nursing specialist | Two days | 6-hour each day | Yes | |
| Molazem, 2013 | Moral distress workshop based on the American Association of Critical Care Nurses' 4As of moral distress | S | Not reported | Weekly for 2 weeks | 4-hour sessions each week | Yes | |
| Saeedi, 2019 | Narrative writing | S | Not reported | At least once a week | 8 weeks | No | No |
| Concurrent Mixed-Method Design | | | | | | | |
| Bevan, 2020 | Conscientization curriculum on moral distress based on Freire's pedagogy. | S | Not reported | Not reported | 3, 4-hour sessions | Yes | |
| Bosshardt, 2018 | Policy change | S | n/a | n/a | n/a | No | Yes |
| Controlled Before-After Design | | | | | | | |
| Beumer, 2008 | Moral distress workshop based on the American Association of Critical Care Nurses' 4As of moral distress | S | Nurse manager, an employee assistance counselor, and a clinical nurse specialist | One workshop (offered over a 4-week period) | 2 hours | Not stated if it was statistically significant | No |

## Table 3-3 Criteria from the MMAT

| | Studies | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Methodological quality criteria** | Abbasi, 2019 | Beumer, 2008 | Bevan, 2020 | Bosshardt, 2018 | Bruce, 2020 | Meziane, 2018 | Molazem, 2013 | Saeedi, 2019 | Vaclavik, 2018 | Wocial, 2017 |
| Qualitative | | | | | | | | | | |
| 1.1 Qualitative approach appropriate | | | Y | N | | | | | | |
| 1.2 Data collection methods adequate | | | Y | N | | | | | | |
| 1.3 Findings adequately derived from data | | | Y | Y | | | | | | |
| 1.4 Interpretation of results sufficiently substantiated by data | | | Y | Y | | | | | | |
| 1.5 Coherence between data sources, collection, analysis and interpretation | | | Y | Y | | | | | | |
| Quantitative randomized controlled trials | | | | | | | | | | |
| 2.1 Randomization appropriate | Y | | | | | | Y | Y | | |
| 2.2 Groups comparable at baseline | Y | | | | | | Y | Y | | |
| 2.3 Complete outcome data | CT | | | | | | Y | Y | | |
| 2.4 Outcome assessors blinded | N | | | | | | N | N | | |
| 2.5 Participants adhere to assigned intervention | Y | | | | | | Y | Y | | |
| Quantitative non-randomized | | | | | | | | | | |
| 3.1 Participants representative of target population | | N | Y | N | CT | N | | | Y | Y |
| 3.2 Measurements appropriate regarding outcome and intervention | | N | Y | Y | Y | Y | | | Y | Y |
| 3.3 Complete outcome data | | Y | CT | N | CT | Y | | | N | CT |
| 3.4 Cofounders accounted for in design and analysis | | N | N | N | N | N | | | Y | Y |
| 3.5 Intervention administered as intended | | Y | Y | Y | CT | Y | | | Y | Y |
| Mixed methods | | | | | | | | | | |
| 5.1 Adequate rationale for using mixed method design | | | Y | CT | | | | | | |
| 5.2 Components effectively integrated | | | Y | Y | | | | | | |
| 5.3 Outputs of components adequately interpreted | | | Y | Y | | | | | | |
| 5.4 Divergences and inconsistencies between results addressed | | | Y | Y | | | | | | |
| 5.5 Components of the study adhere to quality criteria of each method | | | N | N | | | | | | |
| Total % of quality criteria met | 60 | 40 | 60 | 40 | 20 | 60 | 80 | 80 | 80 | 80 |

Legend- Y= Yes, N= No, CT= Can't Tel

*Design category 4 (quantitative description) from the Mixed Methods Appraisal Tool was removed due to inclusion criteria

## Chapter 4 Paper 3: Mitigating moral distress: Pediatric critical care nurses' recommendations


### Abstract

**Background**: Pediatric critical care units are highly specialized and dynamic environments. Advances in technology and extremely complex illnesses can increase the pressure healthcare professionals experience when working in this environment and can contribute to high levels of moral distress. There is limited evidence on what approaches are effective to mitigate the negative effects of moral distress among nurses among pediatric critical care nurses.

**Aim**: The aim of this study is to identify intervention attributes that critical care nurses with moral distress histories deem important in order to develop a future moral distress intervention.

**Methods**: We used a qualitative description approach. Participants were recruited using purposive sampling between October 2020 to May 2021 from pediatric critical care units in a western Canadian province. We conducted individual semi-structured interviews via Zoom.

**Results**: A total of 10 registered nurses participated in the study. Four main themes were identified: 1) "I'm sorry, there's nothing else": increasing supports for patients and families; 2) "someone will commit suicide": improving supports for nurses: 3) "Everyone needs to be heard": improving patient care communication; and 4) "I didn't see it coming": providing education to mitigate moral distress. Most participants stated they wanted an intervention to improve communication among the healthcare team and also noted many changes to unit practices on the unit that could decrease moral distress.

**Conclusion**: To our knowledge, this study is the first study that asks nurses what they need to minimize their moral distress. Our findings suggest that although there are multiple strategies in place to help nurses with difficult aspects of their work, participants identified additional

strategies to help mitigate their moral distress. Identifying what nurses need is necessary to develop effective interventions for moral distress. Further research is needed to evaluate the effectiveness of the intervention.

**Keywords**: Moral distress, qualitative description, pediatric critical care, nurses, interventions

## Introduction

Pediatric intensive care units are highly complex, busy environments with many different healthcare professionals providing numerous forms of advanced life-sustaining care to critically ill children. Medical, surgical, and technological advances have resulted in the sickest children surviving extremely complex illnesses, often only with ongoing care provided in the pediatric intensive care units (Dryden-Palmer et al., 2018; Epstein & Brill, 2005). These advances cause new challenges, such as coordinating care among a team and ethical challenges surrounding end of life care, for the staff working in the pediatric intensive care unit (Epstein & Brill, 2005), and there are higher expectations placed on the healthcare team by the children's families (Foglia & Milonovich, 2011). Even with these innovations in pediatric critical care, not every child's death is preventable. Moreover, children who survive the pediatric intensive care unit may have sequelae requiring lifelong care. These realities can cause stress and challenges for those working in this environment and contribute to the high prevalence of moral distress within pediatric intensive care units (Epstein & Brill, 2005; Prentice et al., 2016). Moral distress "arises when nurses are unable to act according to their moral judgment. They feel they know the right thing to do, but system structures or personal limitations make it nearly impossible to pursue the right course of action" (Canadian Nurses' Association, 2017).

It has been shown that there is an increase in incidence of moral distress in pediatric and neonatal intensive care units compared to adult intensive care units or pediatric wards (Larson et al., 2017). All healthcare providers reported significant work-related moral distress, yet nurses experienced increased intensity (Larson et al., 2017). This increase in intensity may be in part due to the high proportion of nurses as compared to other healthcare professionals in these environments as well as the nature of nursing, the intimacy of the relationship they have with patients, and the structure of nurses' practice (Prentice et al., 2016).

Since Jameton's seminal piece defining moral distress (Jameton, 1984), the body of research has recently shifted from defining and describing experiences of the phenomenon to focusing on developing strategies to mitigate its negative effects (Morley & Horsburgh, 2021). While many interventions to minimize the effects of moral distress have been proposed (Burston & Tuckett, 2012; Carnevale, 2020), there are limited studies that implement and test these interventions (Deschenes et al., 2021; Morley et al., 2021). Further, no studies have been identified that have examined nurses' views on what interventions are needed within pediatric critical care units to minimize moral distress. Therefore, it is not clear what nurses identify as needed interventions for moral distress within these units. Suggestions for future research include developing interventions that are tailored to healthcare professionals in higher-risk groups (Dryden-Palmer et al., 2020), such as nurses working in pediatric critical care. This qualitative study aimed to explore what pediatric critical care nurses identify as a needed intervention to minimize moral distress.

## Methods

### *Design*

We used qualitative description to guide this exploratory study (Sandelowski, 2000) to answer the research question: *What do pediatric critical care nurses who have experienced moral distress identify as needed interventions to minimize moral distress?* Qualitative description generates a low-inference report of a phenomenon and favours a naturalistic descriptive approach over-interpretation (Kahlke, 2014; Sandelowski, 2000). Unlike other qualitative methods, qualitative description presents the data with little interpretation, so the results remain close to the original data.

### *Participants*

Participants were recruited using purposive sampling (Bradshaw et al., 2017) on two Canadian pediatric critical care units between October 2020 to May 2021. Participants were eligible if they were registered nurses who worked in pediatric critical care and self-identified that they had experienced moral distress. No restrictions were made based on nursing experience or length of time working in pediatric critical care. Physical posters were displayed in staff rooms located on each unit. The posters defined moral distress, identified the purpose of the study, and provided contact details and credentials of the study team. An electronic version of the poster was also emailed by the research coordinator or the clinical nurse specialist to all nursing staff in the units. Additionally, we engaged in snowball sampling (Fawcett & Garity, 2008), asking participants to forward study information to nurses they work with who might be interested in the study.

### *Setting*

This study took place on two Canadian pediatric critical care units within an urban tertiary care hospital. These high-intensity units collectively have 31 single patient rooms and nurses on the units care for patients ranging in age from days old up to 16 years, with a variety of critical medical and surgical needs. All patients require intensive one-on-one monitoring and treatment from multiple healthcare professionals, often at the same time. The majority of patients on both units are sedated and ventilated, and regularly have family members at the bedside.

Both units adopt a multi-disciplinary approach to patient care. The healthcare team includes physicians (n=16), fellows, residents, registered nurses (n=> 200), pharmacists, registered respiratory therapists, social workers, occupational therapists, physiotherapists, dieticians, extracorporeal life support specialists, clinical nurse educators (n=5), and a clinical

nurse specialist. On each unit, two highly specialised pediatric intensivists managed patient care during the weekdays and one intensivist per unit covered nights and weekends. In addition, residents and clinical/surgical fellows assist physicians with patient care. The charge nurses (one for each unit) organize and assign nursing care each day in consultation with one of the four unit managers.

The units have several strategies in place to help nurses manage the stressors of their work. These strategies include various personnel a nurse can go to for help (e.g., help with procedures or managing complicated patients) such as clinical nurse educators, resource nurses, clinical ethicists, palliative care personnel, pastoral care, and management. At one point the units had a mentorship program where new nurses were buddied with senior nurses; however, participants are unsure if this is still in place. The Critical Incident Stress Management (CISM) program is in place on both units and consists of a small team of nurses who are specially trained to provide one-on-one support and help facilitate interdisciplinary meetings specifically designed for dealing with acute traumatic events. Additionally, there is a lengthy orientation for both units (approximately five weeks in length). Part of the orientation (less than one hour) is spent discussing supports such as CISM and experiences nurses may have on the unit, including moral distress. Although there were numerous supports in place, none of them were specifically designed to help nurses' moral distress.

***Data collection***

One-on-one semi-structured interviews ranging between 60-90 minutes were completed to explore what participants identify as a needed intervention to minimize moral distress. All interviews were conducted by one member of the research team (SD, PhD candidate at that time) to maintain consistency. The interview guide was reviewed by substantive area experts and pilot-

tested with a small group of nurses to determine the clarity of the questions and ensure that the questions would elicit meaningful information. All interviews were conducted through web-based teleconferencing due to social distancing guidelines. Zoom was chosen due to its simplicity and user-friendliness as well as its security features such as user-specific authentication, real-time encryption of meeting, and ability to backup recordings to local secure networks (Archibald, et al., 2019). After receiving an email from participants stating interest in the study, the interviewer (SD) followed up to schedule an interview at a mutually agreed-upon date and time. All participants completed a demographics questionnaire after written informed consent was obtained. A semi-structured interview guide (Appendix 1) that consisted of open-ended questions was used for all interviews. Interview questions were developed based on the study's aim, the team's research experience, and the key elements of relational ethics (Bergum & Dossetor, 2020). Relational ethics is one lens in which we can examine moral distress through to better understand how we act in everyday ethical situations (Bergum & Dossetor, 2020; Deschenes & Kunyk, 2020). This ethic has four key elements: mutual respect, engagement, embodied knowledge and interdependent environment. Prompts and spontaneous questions were used to understand participants' responses better and gather high-quality data. Interview questions moved from general questions about their understanding and experiences of moral distress to specific questions on potential interventions, with later interviews becoming more focused. All interviews were transcribed verbatim by a professional transcriptionist. Data were de-identified to ensure confidentiality. Data collection and analysis were completed concurrently until data saturation was achieved (Sandelowski, 1995).

### *Data analysis*

Transcripts were uploaded to NVivo 12 qualitative data management software (QSR International, 2017). First, transcripts were read in detail several times. Second, using verified and cleaned transcripts, we conducted open coding and grouped codes into preliminary categories. Coded data were grouped into sub-categories and examined for internal and external homogeneity (Mayan, 2016). Lastly, preliminary themes were developed by further analyzing the categories. The process was initiated by the first author (SD), then verified by the research team. Credibility, dependability and confirmability (Lincoln & Guba, 1986; Morse, 2015) was addressed to enhance rigor. A comprehensive study log was maintained, identifying all methodological decisions and rationale. Field notes and reflexive journaling were used to enhance the understanding of each interview, examine potential bias, develop an audit trail, and further enhance rigor.

### *Ethical considerations*

Ethical approval was obtained from the University of Alberta Health Research Ethics Board, and operational approval was obtained from each unit. Each potential participant received the study information sheet outlining the nature of the study, potential risks and benefits, the voluntary nature of their participation. Participants were given time to look over the information sheet and to ask questions about the research.

## Results

### *Overview*

A total of 10 pediatric critical care nurses participated in this study. All participants self-identified as having experienced moral distress. Demographic characteristics of participants are presented in Table 3.1. Participants' years of experience working as a registered nurse ranged

from 5-12 years, and years of experience in their current role ranges from 2-12 years. The majority of participants (n=8) were between the ages of 30-39 years old. All participants had a bachelor's degree in nursing. Participants were assigned a numerical code that was used as an identifier (e.g., Nurs-00). In this section we will describe the unit circumstances at the time of the interviews as well as common causes of moral distress as voiced by the participants to contextualize the later presented themes.

At the start of data collection, the units were under strict COVID-19 restrictions (limited visitors, personal protective equipment to be worn at all times, anyone with flu like symptoms was not permitted on the unit) and several pediatric nurses were redeployed to adult critical care due to the number of adults admitted in critical condition. Many participants stated that the pandemic and subsequent changes to their work further exacerbated workplace stress, moral distress, and the overall morale among staff members. The majority of participants (n=9, 90%) in our study stated that their moral distress was partly due to challenges or barriers in communication. Other common causes of moral distress among participants included futile care, differences of opinion related to patient care (within the healthcare team and between the team and the families), and the workplace culture. Supporting participant quotes are presented in Table 4.2.

***Themes***

Our analysis generated four main themes: 1) *"I'm sorry, there's nothing else": increasing supports for patients and their families*; 2) "*someone will commit suicide": improving supports for nurses* with subthemes a) *receiving help to navigate their psychological and emotional distress;* and b) *strategies to build morale and enhance unit culture;* 3) *"everyone*

*needs to be heard": improving patient care communication*; and 4) *"I didn't see it coming": providing education to mitigate moral distress.*

***Theme 1: "I'm Sorry, There's Nothing Else": Increasing Supports for Patients and Families.***

Participants expressed that improving supports for patients and their families throughout their time in pediatric critical care would help mitigate nurses' moral distress. Participants noted that having more immediate involvement of specialty services such as pastoral care, palliative care, and social work for complex or chronic patients; increasing supports to improve patients' quality of life while on the units; and providing supports for families to navigate difficult decisions, would be beneficial to improve the patient care experience and to help mitigate nurses' moral distress. According to participants, these supports could decrease nurses' moral distress by improving the quality of patient care, knowing that the family has designated supports in place when making difficult decisions, and potentially minimizing futile care required by the nurse.

Participants discussed that improving the utilization of pastoral care, palliative care, and social work to work with complex or chronic patients would be beneficial to support the patients and their families throughout their time in pediatric critical care. This support could improve the patient care experience by having specialists involved in care sooner, support families by helping to answer medical and non-medical questions, or by assisting them in navigating their stay in the hospital. One participant said, "in the future, when we can recognize that these patients are very ill and truly palliative …we should have the [palliative care] team involved because they are the specialists." (Nurse-03). Another participant noted that automatic referrals to palliative care would be beneficial because "when you're getting to the more difficult decisions, you've had them involved the whole way, so they're not new faces showing up." (Nurse-06). Participants

identified that automatic referrals to these resources based on diagnosis, surgical intervention, or family circumstances would help improve access and provide valuable support to both the patient and their family.

Participants also discussed that supporting patient care by focusing on medical procedures and the patient's quality of life while staying on the unit could reduce nurses' moral distress. One participant described a difficult situation she found morally distressing that could have been minimized by improving a patient's quality of life,

> "We had a kid on ECMO for months and months and months, and all she wanted to do was like eat and drink, and she was not going to live. She had almost no chance of living and she was miserable and at the bedside, you're the one saying no, you can't eat or drink and to me, that's not an acceptable quality of life. Like if all she wants to do is eat or drink and whatever. We cannot facilitate that because she's too unstable to eat or drink, and she's miserable, and she has zero way out. That's not okay for me, and the kid ended up dying in a horrible arrest after months. And I was just like, ah, I wish they gave her some coke yesterday so she could've at least had enjoyed that simple pleasure." (Nurse-06).

The participant continued by stressing, "if we're going to do those things [medical procedures], we need to balance it and say, okay, we need to spend resources making their life acceptable to them if they're going to live here." (Nurse-06). Other suggestions to support patients' quality of life included implementing protected rest times, grouping medication administration when possible, and taking chronic patients off the unit for a change of scenery. Participants described that some of their patients have been on the unit for almost a year, and improving their quality of life could improve the family's life by seeing their child enjoy simple pleasures as well as easing nurses' distress associated with the actions or decisions required to care for the patient.

Additionally, numerous participants recognized the burden the healthcare team puts on parents when asking them to make difficult healthcare decisions. Many participants acknowledged that few supports were in place to help families work through tough decisions. They expressed that providing support to families throughout the decision-making process would be highly beneficial. Participants noted that these supports could especially help families navigate their emotions, grief, and stressors that often accompany the decision to withdraw care when there is nothing else medically that can be done for the patient. Participants felt that this support could minimize their moral distress by knowing the family has someone designated to talk to during these difficult situations and minimize possible futile care required by the nurse. One participant stated,

> "I find sometimes moral distress issues come from the fact that the onus of the decision of the kids sometimes is placed on the parents. … We know what the obvious [decision] should be, but we give it to the parents and the burden of that sometimes causes prolongation [of care] and the distress that we see — and I've seen a lot." (Nurse-05).

When describing one situation, a participant recognized that "[the family] were the ones that had to make the decision, and I think as a parent living with that long-term is more difficult than having someone say to you, there's nothing else. I'm sorry, there's nothing else." (Nurse-06). Emphasizing the difficulty of these situations, she further added, "I think if somebody said, do you want to keep trying for your child, there's only like a 5% chance, I'd be like for sure. But it's hard to make decisions like that for your child." (Nurse-06). In those difficult situations, nurses often felt powerless when supporting families through the decision-making process, and this feeling contributed to their moral distress. Participants felt that this support should be a

psychologist designated for the families to help them manage any psychological challenges that often accompany having a child in critical care.

One participant said,

> "we could *always* use a shared psychologist that not only caters to the patients, but also deals with parents because sometimes some of these things that contribute to moral distress is not the team per se; it's the team saying that this is all we can do. We should withdraw care and parents are not ready." (Nurse-05).

In these ways, participants felt that having proper support in place to help families navigate difficult healthcare decisions would help to alleviate their own moral distress.

***Theme 2: "Someone will Commit Suicide": Improving Supports for Nurses.***

In addition to supporting families, many participants discussed that improving supports for nurses would help minimize their moral distress. This theme is divided into two subthemes a) *receiving help to navigate their psychological and emotional distress* and b) *strategies to build morale and enhance unit culture.* In the first subtheme, participants made numerous suggestions of supports that could facilitate coping with the psychological and emotional stressors associated with moral distress that can be common among nurses working within a high-stress environment such as pediatric critical care. In the second subtheme, participants described several current unit practices that could exacerbate their moral distress and suggested strategies to improve these supports, build morale, and minimize moral distress.

**Receiving Help to Navigate Their Psychological and Emotional Stressors.** Several participants noted that resources are needed to facilitate nurses' coping and manage the toll that working in an extremely high-stress environment takes. These interventions include resources to

help nurses navigate past and future morally distressing situations and increase their awareness of resources that promote self-assessment and self-reflection of their moral distress.

Several participants noted that resources are needed on the unit to facilitate nurses managing the toll that working in such a high stress area takes. One resource that was suggested was having a designated psychologist available to help nurses navigate their psychological and emotional stressors related to moral distress experiences. One participant urgently pleaded that "someone will commit suicide" (Nurse-01) if support was not increased. Another participant said, "it would be nice to have a designated therapist available for people on the units to talk to you one-on-one. I think it's very important." (Nurse-09). Although the health benefits package for nurses covers some counselling, it was noted that it is still costly and can be difficult to access. One participant noted, "it's expensive. It's $200 and benefits only cover half of that. I could see how that would be financially straining." (Nurse-08). For this reason, numerous participants felt that a psychologist could provide confidential one-on-one support to help nurses work through morally distressing situations. One participant postulated, "during the one-on-one, I think people would [talk] more on the personal level of what they've been through during the [morally distressing] situation, which would improve the moral distress that people feel afterwards." (Nurse-07). Another participant asserted that "…we're working with people and if you make a mistake that costs somebody their life, for example, or contributes their deterioration, that's a really difficult thing for people to deal with. [Therapy's] ultimately what we need." (Nurse-04).

A few participants reported that improving awareness of existing moral distress supports and how to navigate these supports is also needed. Participants suggested having a poster outlining common signs and symptoms of moral distress and current moral distress resources

offered on the unit with details such as contact information or when one could use the supports would be beneficial. Participants felt that this poster would be helpful because nurses could self-assess their moral distress, know what resources are available, and access appropriate resources. This information could also help to normalize nurses seeking help for moral distress. One participant stated what would help her is "an algorithm kind of sequence that if you take one step and you're still feeling distressed, there's another step that you can go to and if you're still feeling distressed in that situation, then you escalate to maybe professional counselling." (Nurse-04). She continued to say that currently "there's no obvious process. I felt I needed that." (Nurse-04).

Additionally, participants indicated that a brief confidential questionnaire from management to check in with nurses after critical incidents would be helpful to encourage self-reflection and increase nurses' awareness of any moral distress they may be experiencing. The questionnaire could examine how the nurse was coping after an incident and determine if support, such as counselling, is needed. When describing what the questionnaire could look like, one participant said, "Just a simple yes, no, questions, like have you talked to anybody about this? Do you want to talk to somebody about this? Do you think it would help you?" (Nurse-04). Overall, participants felt that talking to a psychologist, having a poster outlining existing supports, and being sent a brief questionnaire after critical incidences could help increase awareness of their moral distress and navigate psychological and emotional stressors.

**Strategies to Build Morale and Enhance Unit Culture.** Participants discussed that current unit practices might be exacerbating nurses' moral distress, and implementing new strategies or processes to build unit morale and enhance unit culture could help to mitigate the phenomenon. Nurses suggested numerous interventions to refine unit practices and build morale, including increasing nurses' autonomy, changing the practice of who should be a charge or

resource nurse, frequently changing nursing assignments for complex patients, and bringing back small gestures to build morale.

First, participants stated that their lack of autonomy and restricted scope of practice on the unit exacerbates their moral distress. More specifically, they recommended increasing nurses' autonomy by enabling them to work to their full scope of practice, empowering them to have more decision-making capacity, and removing some institutional barriers to improve patient care and, therefore, potentially minimize their moral distress. One participant said,

> "I found I've had the least autonomy working in [province] and that's been hugely morally distressing for me. And I found there's much more of a hierarchy here that also contributes to it, just this feeling like you're at the bottom and you have little influence as to what's going on with your patient and ability to make changes." (Nurse-06).

She continued by describing what would help to minimize her moral distress,

> "I think just giving people autonomy to do things too would be good. Like I think if I said I feel comfortable taking this kid off the unit who is trached because I have training.[1] I'm trach trained and they say, well we don't have any RTs, you can't go. …. Like there's just some big organizational barriers to cross. So, I think that's hard too, but somehow giving more autonomy to those kinds of things would be really nice. I would love to take these kids out of the unit who've lived there for months and months, but I'm not allowed to do it because you need to have three people to go with you, and there's never staffing to accommodate that kind of entourage. So, it's so limited." (Nurse-06).

Second, participants recommended changing the practice of who should be a charge or resource nurse on the unit. One aspect of these roles is to help support nurses on the unit if they

[1] Short for someone who has a tracheostomy- a surgical opening created through the neck into the trachea (Johns Hopkins University, n.d.).

run into any challenging situation or need an extra hand to complete patient care. The current practice is that nurses with a certain amount of clinical experience are expected to take on these leadership roles and do not consider personality traits such as patience and approachability. Participants stated that selecting these roles should be based on experience along with personality to have more approachable nurses as charge or resource nurses so they feel comfortable asking for help. One participant said,

> "I would want someone to listen. I would definitely want people that I can go to and trust. I think there's certain people who can take on certain roles and the problem is, I think, sometimes there's an expectation for everyone to take on the same role on a unit and I don't think that works out for everyone. Not everyone can be a charge nurse. Not everyone can be a resource nurse. There are some roles that I think should be definitely shared with staff who can do those roles. Those roles should be shared between people who are more compassionate." (Nurse-01).

Another participant described how lack of support affected her stating,

> "When you have someone that you can't trust or to talk to or to ask for help, even if it's to grab you something or, you know, talk to about some sort of issue that happened on the unit, you really feel constrained. You feel like your world has definitely gotten a lot smaller." (Nurse-01).

Participants discussed that having unapproachable nurses in these roles exacerbates their moral distress because they do not have the support required to properly care for their patients from the leaders whose role is to support them.

The third suggestion participants made to refine unit practices and build morale was to implement unit practices to ensure nursing assignments for complex patients are changed

frequently. Participants felt that changing assignments regularly would share the emotional and mental labour that accompanies these complex cases and minimize their moral distress. Participants noted that automatically changing assignments would eliminate the need for the nurse to ask for a new assignment and deal with a potentially difficult situation by asking. One participant described a situation where she felt powerless when asking for a new assignment. She stated,

> "I won't ask for a new assignment anymore. It's not worth the pushback that you get, but I know that that's not okay. … How much fight should I have to put in to advocate for myself? And if you get beat down so many times when you're already struggling, it's not worth it." (Nurse-02).

Participants felt that even if the charge nurse is supportive, having this practice in place would take the onus off the individual nurse to ask for a new assignment when caring for a complex patient. This change to unit practice would help the nurse feel supported by their workplace, could enhance unit culture, and contribute to minimizing their moral distress.

Lastly, nurses suggested bringing back small gestures of appreciation to build morale. In the past, the unit would bring in a massage therapist to massage staff while on their breaks and on other occasions order pizza. The staff paid for these gestures but participants felt it was a great way to increase morale. One participant shared,

> "In helping to de-stress pre-COVID, there was a time that a massage therapist that came to the unit and she would provide like a 10-minute massage to anyone. … It helped with morale. I remember she'd come in and everyone felt happy." (Nurse-09).

Although these are small gestures, participants recognized they made a significant impact on improving morale. However, they recognized these activities might be challenging to implement due to the coronavirus restrictions that were in place during the time of the study.

One participant felt that there was adequate support currently being offered for nurses, including a poster outlining stress responses with a list of resources if needed and numerous personnel a nurse can go to for help. However, this participant held a different role on the unit than the other participants. Other participants acknowledged the poster, and stated that the poster hung in the bathroom and did not specifically address moral distress, therefore did not provide support to navigate morally distressing situations.

***Theme 3: Everyone Needs to be Heard: Improving Patient Care Communication.***

Most participants shared that improving patient care communication among the healthcare team is necessary to minimize their moral distress. They noted that a lack of clarity regarding medical decisions contributed to their moral distress and believed improving patient care communication would be beneficial. One participant declared, "communication goes a long way… and ever since I started on these units, in comparison to other places, we're not very good at that." (Nurse-02). Participants outlined existing interventions to facilitate patient care communication included townhall meetings, debriefings, weekly written patient updates, and electronic health records. They described necessary changes to these interventions for improving communication and minimizing their moral distress. These focused on establishing unit practices to ensure the interventions are consistently implemented, predictable, and take place in an environment to foster communication.

Participants explained that townhall meetings are currently in place on the units on an ad hoc basis. The current meetings are typically initiated by a nurse or a member of the CISM team in response to a patient situation, often after it has become complicated due to escalation of patient care or lack of clarity around medical decisions. These meetings are intended to provide clinical information and rationale for patient care decisions to the healthcare team. When discussing the benefits of these meetings, one participant said,

> "You know, I think they're helpful… the good thing about it is that you can ask questions and you usually get pretty comprehensive responses of why decisions have been made… it's an opportunity to just connect to others about how they feel and to see that you're not the only one feeling these things. These can be very validating and really ease your moral distress." (Nurse-03).

However, participants stated that the current town hall meetings are hit or miss in quality depending on who is facilitating the meeting and can be unproductive or even worsen the situation. One participant stated, "It is *very* fluctuating, depending on the physician running that meeting." While another participant purported,

> "I think sometimes people end up arguing …I think the idea is usually to listen to people and I think people have a listening problem, especially a lot of our physicians. I think a lot have lost patience and so when people stop listening and they just start arguing in return, no one gets anywhere, and then people just get upset." (Nurse-01).

Participants noted that establishing unit practices that are consistently implemented, determined a priori, and based on best practices to conduct townhalls, are needed to improve these meetings. First, participants suggested that patients meeting specific criteria (i.e., diagnosis, length of stay, or family situations) need to be automatically discussed in town hall meetings.

This proactive process would take the pressure off the nurse to ask for a town hall meeting to discuss the complex patient. One participant stated, "I also think it could be good to have a trigger [to call a meeting] that people don't have to ask for it, that based on certain criteria you could look at the patient census and go like, this is going to be tough." (Nurse-02). Second, participants stated that complex patients should be discussed shortly after admission and again if there are any significant changes such as surgeries, codes, or changes to their goals of care. One participant said,

> "I think if we brought in the support earlier, like right when the situation is starting or midway through when we are recognizing that the emotions are high and that people are struggling or feeling torn, I think would have a better outcome instead of just trying to address it after the moment because then people have already struggled through it all, and then they are either burnt out and don't want to talk about it and just want to forget it and block it versus actually, you know, acknowledging what they have gone through." (Nurse-07).

Third, it was noted that town hall meetings should be run systematically to minimize potential bias and make the meeting more productive no matter who is facilitating the meeting. One participant stated,

> "If you have a physician who is well-spoken and, you know, empathetic, you can get a lot more out of the meeting because you get better detailed answers and better kind of validation of your emotional standing and how it's being distressing for you." (Nurse-03).

Participants felt that having a standardized checklist of talking points (e.g., upcoming procedures, goals of care, family supports, etc.) for each patient would reduce the power

dynamics among team members about patient care and therefore interdisciplinary communication and increase attendance in the town halls.

Another existing intervention identified for enhancing team communication was debriefing sessions after traumatic events.[2] Debriefing sessions currently occur on the units and have been beneficial; however, these sessions occur inconsistently and are not always facilitated effectively, further speaking to the need for standardized and consistent approaches. Participants discussed that having standardized debriefing sessions after every traumatic event would be helpful to unpack the situation. One participant shared,

> "If there was more of a standard protocol after a code or a traumatic event, if we could find something that was more standardized, we go through the motions and hit every part of moral distress rather than sometimes after a code [when] we do debrief and sometimes we just don't. So, if it was something that was just done routinely and done in the same way, then in that way nothing gets missed and nobody gets missed." (Nurse-08).

It was suggested that these debriefing sessions should occur as soon as possible after the event and include all members of the team, "every member of our team should be–represented and be part of it; management, physicians, nurses, respiratory therapists, everything." (Nurse-01).

For the town hall meetings and debriefing sessions, participants emphasized that the environment in which this communication takes place is essential to consider. Participants shared that these interventions need to occur in a 4, non-judgmental, and welcoming space, free from hierarchal structures often exhibited among healthcare teams. For this reason, participants felt that the town hall meetings and debriefings would be best led by someone who had specific training in counselling or debriefing; however, the primary physician would need to be present to

[2] A traumatic event is one that causes a great deal of stress and marked by a sense of horror, helplessness, serious injury or death (Center for Disease Control, n.d.)

answer specific medical questions and provide detailed guidance. Once the meetings have been up and running effectively, then someone from the team could take over,

> "I think eventually we need to lead – obviously, we need to solve it or we need to fix our own unit. But I think people are in the mess right now, and they're so burnt out, nobody knows what to do. Nobody is willing to listen, everyone is just willing to just tell their opinion, without any sort of filter and any sort of understanding of the consequences of saying their opinion. And so, I think we definitely need help, for sure. But if it's someone who has to lead us in the immediate term, it would be, I think, somebody outside of the mess who teaches us how." (Nurse-01).

Participants also discussed the re-implementation of weekly written patient updates. They explained that this form of patient care communication previously occurred but has been dropped. In the past, written patient updates were sent out virtually at the end of each week by the clinical fellow on service. These updates were on all the chronic patients to inform the healthcare team about how the patient's week went and the plan of care going forward. Participants noted that this intervention was quite helpful to keep everyone up to date on what was happening medically with chronic patients. One participant purported, "I find that the weekly updates really helped in the sense that it's coming from the physician team to update us on what the plan is … to help guide us." (Nurse-09). Overall, participants felt that it would be beneficial if they were re-implemented and could include brief updates for each chronic patient, written by the clinical fellow, and securely sent out to all healthcare professionals on the unit.

The last venue that participants discussed to improve patient care communication is optimizing electronic health records to provide nurses with easy access to patient updates, in a way that does not breach patient confidentiality, to inform them of the most recent medical

decisions, the family's involvement, and whether any specialists or consultants have seen the patient. Nurses discussed that the current process of reading through the chart is inefficient, frustrating if the information is hard to find, and can contribute to moral distress because they are not aware of or up-to-date on conversations regarding patient care. One participant said, "If we can create a section in the chart or a place for those key things like the ethicist's information, that up until last week I didn't know was there, that you can access without it being a breach to confidentiality." (Nurse-02). Overall, participants felt that these four venues could be optimized to improve patient care communication, increase clarity surrounding patients' medical decisions and minimize their moral distress.

Alternatively, one participant stated that CISM program implemented within the unit does not focus on feelings, and it does not fix anything because "we're not psychologists. We can't fix. That's not our job. Our job is peer support" (Nurse-10). However, she felt that the CISM was a sufficient communication intervention for minimizing moral distress given the quality of the peer support and the ability to refer to a Registered Psychologist if needed. This participant was dissimilar to all others interviewed by virtue of her role in the unit.

***Theme 4: I Didn't See it Coming: Providing Education to Mitigate Moral Distress.***

Participants reported that increasing education on communication strategies and moral distress would be beneficial to minimizing their moral distress. This education would provide them with needed strategies to effectively communicate and recognize and address moral distress. Several participants identified that modules on empathetic listening, assertiveness, difficult conversations or conflict resolution would be beneficial by empowering them with the necessary skills to better communicate with colleagues, patients, and their families. Participants stated that these communication modules could be done individually online and could occur as

part of orientation as well as part of their annual continuing competencies. One participant identified,

> "I think that in orientation, we could benefit from …communication skills in difficult situations…. I could use more tools for these situations because it's not something I enjoy and it makes me feel anxious and so if I can avoid it, I will…. I think [communication skills for difficult situations] could also be helpful because it can be applied to whether you're struggling with your team, you're struggling with your patient, you're struggling with their family. [It's] just one more tool to set people up for being able to speak up and not keep it to themselves and not have those moments where you wish you could've done it differently." (Nurse-02).

Another participant explained, "I think just everyone needs to be heard… everyone needs to be educated on how to communicate and how to–I don't know, just maybe display compassion, kindness, very basic–I think it's not complicated, whatever it is." (Nurse-01).

Participants also suggested that increasing opportunities for moral distress education is needed to empower nurses with the knowledge and skills to mitigate their moral distress. Participants stated that there is minimal moral distress education currently available and proposed that this education take place in orientation to increase awareness of potential morally distressing situations. It was also stressed that moral distress education should not only occur in orientation but also as nurses become more experienced on the unit and exposed to more complex, and therefore potentially more morally distressing, experiences. She explained, "the more experience you get, the more sick and complex patients you get, and the more likely [you are to experience moral distress]." (Nurse-06). Participants stated that moral distress education could occur as group education or individually directed as an online module. At a minimum, it

should include signs, symptoms, and existing resources that staff could access if they need help. When discussing how important education on moral distress was, one participant shared,

> "I knew that when I signed up for this job that there were sacrifices; you prepare for weekends and holidays away from your family and long hours and whatever life expectancy you're losing to shift work, but I wish I had been more prepared for this. I still would've signed up to do it, but it wasn't even on my radar that this is something that I was going to experience. So, not only did I not have the tools to know what to do about it, I didn't even see it coming." (Nurse-02).

Another participant said,

> "It's just such a hard thing, and when you look at the literature, it's like there's so much proof that it's a problem. But there are no interventions. I think even awareness is important. Like being aware that it's a problem and talking about it is a good thing." (Nurse-06).

Overall, participants noted that increasing education on both communication strategies and moral distress during orientation and as part of their annual continuing competencies would minimize their moral distress. They felt that education on these two topics would empower them by increasing their awareness of moral distress as well as providing the tools they need to better prepare for difficult situations. Participants felt this education was essential to help alleviate their moral distress.

**Discussion**

Moral distress is an experience of anguish when one is unable to act in a way that aligns with their ethical principles. This phenomenon is complex and can only occur within relationships, relationships between the nurse and their own thoughts, feelings, experiences, and

values, among team members, with the patient and their family, and within the larger societal conversations. This study sought to uncover what 10 pediatric critical care nurses working on two Canadian pediatric critical care units identified as needed interventions to minimize moral distress. Participants in our study identified numerous interventions that could minimize their moral distress and we have organized our discussion related to our key findings: increasing supports for patients and their families, improving supports for nurses, improving patient care communication, and providing education to mitigate moral distress.

### *Increasing Supports for Patients and Their Families*

Participants in our study expressed that increasing supports for patients and their families to improve the patient care experience could help minimize their moral distress. The potential role of increasing patient and family support in alleviating nurses' moral distress is a novel finding that has not been explored in the moral distress literature. These findings are not surprising given that many contributing factors of moral distress are linked to the patient care experience, for example, nurses providing care that they perceive is unwanted, perceived lack of competent care, diminished quality of care, perceived feelings of loneliness at the end of life, and inadequate pain management (De Brasi et al., 2021; Forozeiya et al., 2019; Henrich et al., 2016; Larson et al., 2017). In our study participants described improving the utilization of social work, palliative care and pastoral care as one possible strategy to improve the patient experience. In Helmers and colleagues' (2020) qualitative study exploring moral distress experiences among pediatric intensive care unit nurses, participants identified the need for formal supports, including social work and palliative care services. It is unclear in their study if there is a link between these recommendations and improving patient care that in turn would minimize participants' moral distress (Helmers et al., 2020).

The nature of nurses' work keeps them physically close to the patient, sharing the same space and developing a relationship. The patient's experience at some level must reside in the nurse. Why else would the nurse experience such distress witnessing the child or family suffering and feeling powerless to relieve that suffering? Examining ways to improve the patient experience could not only improve patient care but can potentially minimize nurses' moral distress. These findings need to be explored further in future moral distress research.

***Improving Supports for Nurses.***

Our findings suggest that improving supports for nurses could minimize their moral distress. Participants in our study indicated that having a psychologist available to aid them in navigating morally distressing situations could be beneficial. De Brasi and colleagues (2021) conducted a phenomenological study examining moral distress among Italian nurses. They found that meeting with a psychologist can be beneficial for nurses to reflect on their morally distressing experiences. Vig (2022) suggests that easy access to mental health support and time to access this support is necessary to reduce moral distress among healthcare staff. Wall and colleagues (2015) found that critical care nurses need psychological support to navigate morally distressing situations. However, participants in their study suggested that this psychological support ought to be in the form of mentorship. Similarly, in Forozeiya and colleagues (2019) study examining moral distress in the intensive care unit, novice nurses found that leaning on more experienced colleagues for support and mentorship was beneficial to help them work through their morally distressing experiences.

Nurses in our study did not suggest mentorship as a possible strategy to minimize their moral distress, but they did suggest strategies to build morale and enhance the unit's culture to

better support nurses and minimize their moral distress. These findings are echoed in the moral distress literature. Woods (2020) conducted a national survey among New Zealand nurses. They found that poor ethical climate, lack of morale, and lack of support from the healthcare system contributed to nurses' moral distress. Larson and colleagues (2017) state that moral distress was inversely associated with perceived hospital supportiveness among neonatal and pediatric intensive care unit providers. Alternatively, Ventovaara et al. (2021) found that pediatric oncology nurses' perceptions of a positive ethical climate were inversely correlated with their moral distress. Researchers suggest that this may result from having competent and supportive co-workers (Ventovaara et al., 2021). Nurses should not be expected to resolve their moral distress without proper support. The environment, including everyone within it, plays a role in the morally distressing situation. The environment supports and encourages certain choices and behaviours through its policies, demonstrations of support or neglect, and how it enables individuals to engage with one another or seek help. Creating an environment that supports individuals and develops a sense of community can mitigate nurses' moral distress.

***Improving Patient Care Communication.***

Our findings reveal that poor communication surrounding patient care issues contributes to moral distress. This finding is congruent with findings in other studies where poor communication has been shown to contribute to moral distress (e.g., Browning & Cruz, 2018; Coville et al., 2019; Henrich et al., 2016; Larson et al., 2017; Morley, Ives, et al., 2021). Participants in our study purported that interventions to improve communication among the healthcare team are necessary to minimize their moral distress. In Helmers and colleagues' (2020) study participants suggest debriefing sessions to minimize their moral distress. Vig

(2022) recommends facilitated discussions about morally distressing situations that do not aim to fix the situation but to discuss moral distress and the sources of moral distress to help alleviate the negative effects of the phenomenon. In one interventional study examining the results of weekly inter-professional rounds on moral distress levels, Wocial et al. (2016) found that their intervention decreased overall moral distress scores, with a statistically significant decrease in three *Moral Distress Scale-Revised* (Hamric et al., 2012) survey items ("initiate extensive life-saving actions when I think they only prolong death," "work with nurses or other healthcare providers who are not as competent as the patient care requires," and "witness diminished patient care quality due to poor team communication") when comparing matched pairs among nurses. Additionally, this intervention positively impacted participants' ability to communicate with the team and with the patient and family (Wocial et al., 2016). Morely and Horsburgh (2021) found a promising approach to mitigate moral distress among healthcare providers in their case study examining the effect of moral distress reflective debriefs (MDRD). Browning and Cruz (2018) state that ICU nurses expressed frustration regarding poor communication related to patient care and found that facilitating communication in an interprofessional setting is highly important to address moral distress. These studies suggest that strategies to increase team communication could be one potential strategy to minimize moral distress; however, merely presenting an opportunity to communicate may not be enough.

Participants in our study described feeling frustrated during existing interventions intended to facilitate healthcare team communication. They explained that they need a safe space to have these difficult conversations and felt that having someone who is trained to facilitate communication would be beneficial to improve the outcomes of these meetings. These findings parallel previous research in the field stating that clinical ethicists, social workers, or other

individuals trained to provide psychological support are well-positioned to assist colleagues during morally distressing situations (Browning & Cruz, 2018; Morley & Horsburgh, 2021; Wall et al., 2015). Needing a safe space to communicate and navigate morally distressing situations is no surprise. These situations occur within relationships, and repairing the rupture in those relationships needs to occur in a dialogical manner, as suggested by the participants in our study and other researchers. How can we take such complicated and ethically charged situations and expect to find common ground without proper communication or even a sense of being heard? Creating a space that fosters communication by recognizing ethical complexities and the potential for numerous possibilities is well situated to discussing morally distressing situations. Strategies to improve patient care communication should be examined as a potential strategy to minimize moral distress.

***Providing Education to Mitigate Moral Distress.***

One participant exclaimed that she felt blind-sighted by moral distress because she did not even see it coming. Participants in our study suggested that educational interventions on moral distress are needed to recognize symptoms and effectively address moral distress. Abbasi et al. (2019) conducted a mixed-methods study examining the effects of a moral empowerment program on nurses' moral distress. This intervention focused heavily on providing nurses with education on moral distress, including the definitions, signs and symptoms, adverse consequences, and strategies for reducing the effects of moral distress. Abbasi et al. (2019) found a statistically significant reduction in mean moral distress scores. Similarly, Molazem and colleagues (2013) found that providing moral distress education to cardiac care unit nurses significantly reduced their moral distress. The researchers state that moral distress education empowers nurses to discuss and resolve their moral distress (Molazem et al., 2013). In their

literature review, Burston and Tuckett (2012) propose that moral distress education is essential to mitigate the negative effects of the phenomenon. Providing nurses with the proper education to identify and name their moral distress is a crucial step to begin mitigating the many negative effects of the phenomenon.

**Limitations**

Study interviews were conducted at a single point in time and during a pandemic; therefore, the results of our study may differ under different circumstances. We relied on participants' self-report of their moral distress experiences and suggested supports, and thus recall bias may be present. Additionally, the sample may be biased due to the self-selection nature of the recruitment process. While recruitment was open to all nurses working in pediatric critical care, we only received interest from female nurses, which make up approximately 75% of nursing staff. Similarly, we did not receive any interest from nurses working in their current unit for more than 12 years. Therefore, our results may not reflect the needs of these groups. Due to the nature of moral distress and the impact the working environment has on it, the results of this study may not be generalizable to other healthcare professionals, units, hospitals or regions.

**Conclusion**

Exploring what pediatric critical care nurses identify as needed interventions to minimize moral distress is crucial to identify effective strategies to reduce the negative impact of this phenomenon. What is unique about this study is that we sought to explore nurses' views on what interventions are needed within pediatric critical care to minimize their moral distress. Our findings indicate that although numerous strategies are in place to aid nurses with challenging aspects of their daily work, participants identified further potential strategies that would help minimize their moral distress, including interventions that increase supports for patients and their

families, improve supports for nurses, improve patient care communication and provide education on moral distress and communication strategies. Further research is needed to develop interventions based on these findings and pilot test the interventions to see if they are effective. If effective, the interventions should be tailored to other healthcare professionals and units.

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**Table 4-1 Characteristics of Participants (n=10)**

| Characteristics | Participants, n |
|---|---|
| Preferred gender identity | |
| Female | 10 |
| Age | |
| 20-29 | 2 |
| 30-39 | 8 |
| 40+ | 0 |
| Highest level of Education | |
| Bachelor's degree | 9 |
| Master's degree | 1 |
| Years practicing as an RN | |
| Less than 5 | 0 |
| 5-9 | 5 |
| 10-15 | 5 |
| Years working in their current unit | |
| Less than 5 | 4 |
| 5-9 | 5 |
| 10-15 | 1 |

**Table 4-2 Participant quotes on causes of moral distress**

| | |
|---|---|
| Lack of communication | • The physicians try to have a really good rapport with the families, but when they are only in and out for 10 minutes to talk to them, or 20 minutes, sometimes we do not feel like our voice is heard, as nurses, as to how awful the situation feels. And sometimes we want to speak up and be like, hey I think the family has had enough, or I do not think they want to push forward. But then there is always another physician or surgeon that comes in and just gives them this false sense of hope, and we cannot really say anything against that. Nurse-07<br>• So, for nurses who don't understand where the physicians are coming from and I especially have been one of those, it really does just look like we're torturing him [the patient]. It's like he almost died last night and here we are prolonging that. Like why aren't we having the conversations with the family about long-term prognosis and, you know, the likelihood of him getting better. Nurse-04 |
| Futile care | • Continuing to care, prolonging care of a patient with a life-limiting diagnosis is a hard descriptor, because that doesn't necessarily mean death is imminent. I more mean prolonging care when death is the *only* foreseeable outcome. And I know it's hard to say that. I know anyone would say, well, we never know. But when death is *truly* like 99 percent the most likely outcome, and I'll say in the two [situations] that I'm thinking of, the patient died and the death ended up being traumatic for staff, yes, but I'm assuming also for families. Unfortunately, after the death happens you never really have that discussion with the family of how it went but as a health care provider, that's an assumption on my part. That it wasn't peaceful, for lack of a better word, for the family. Nurse-03<br>• We have a patient right now who was found unresponsive at home and has been diagnosed with SIDS, but is two percent shy of brain dead, two percent not being exact but they meet almost all the criteria, but there's just a very tiny bit of brain activity and that we have kept alive for months now because the family believes that their child is going to be miracle because God is going to save them. And sometimes we're giving false hope, but this hasn't been the situation, the family threatened to sue and so we've continued to do everything…. We've been forced to do a lot of the other stuff. …We've done this for months and every time we walk into the room, the family writes down your name. They're not doing it because they wanted to write you a thank you card, they're doing it either because they want to add your name to the lawsuit that they threatened or if you do this slightest thing that they don't agree with, that they're going to complain to someone in spite of us doing |

| | |
|---|---|
| | everything. …And it's just hard to watch because even if she isn't really there or maybe a bit of her still is because there is a tiny bit of brain activity, but what we're doing is not right. Nurse-02 |
| Difference of opinions related to patient care | • Sometimes I think I want something different than what other families may want and that is my own burden to carry in the sense that I need to accept that what I think is right is not necessarily what's right for someone else. Nurse-02<br>• In all of the cases there's that family element because we are in the pediatric setting. And so, in some cases the family element is lovely and supportive. The fact that there is that disconnect between what the plan of care that the healthcare professional wants versus what they're able to do with the support of a loving family can be really hard because they want to be there for the family but they don't agree with the plan of care. Or the other end of the spectrum is that the family is really challenging. And so, it's difficult to communicate. It's difficult to empathize. And so, you've got that divide, that disconnect but you've got no way to sort of bridge the boundary and have that mutual respect and understanding despite the difference of opinion. Nurse-010 |
| Staff dynamics and unit culture | • There was a medication error. Oh, I can't remember exactly the date, but within the first year that I was working, where a whole bag of TPN infused into a baby and I experienced some distress around that….What happened was this was a high alert medication which whenever we have high alert meds, we're meant to be double checking not only the bag, but your meds that go into the room, verify the pump, make sure the infusion rate is correct. And so, in this situation, I was the nurse who should've done that double check but our unit culture, at the time, was that you shouldn't have to do that. It's kind of like overstepping on the other nurse if you go in and you verify that. Nurse-04 |

## Chapter 5 Paper 4: Developing an Evidence-and-Ethic Informed Intervention for Moral Distress


### Abstract

The global pandemic has intensified the risk of moral distress due to increased demands on already limited human resources and uncertainty of the pandemic's trajectory. Nurses commonly experience moral distress: a conflict between the morally correct action and what they are required or capable of doing. Effective moral distress interventions are rare. For this reason, our team conducted a multi-phase research study to develop a moral distress intervention for pediatric critical care nurses underpinned by a relational ethics lens. Informed by this lens, relationships are prioritized as ethical action occurs in relationships. In this article we discuss our multi-phase approach to develop a moral distress intervention – proactive, interdisciplinary townhall meeting. Using the TIDIER framework we inventory all aspects of the intervention. We identify future research needs including consultation with stakeholders to finalize the development of the intervention and pilot test and evaluate the intervention. Our proposed intervention is a sequential compilation of empirical work couched within a relational ethics lens thus should point to enhanced potential for intervention effectiveness.



**Keywords**: intervention development, moral distress, nurses, relational ethics

**Background**

The global pandemic has created unprecedented challenges for healthcare professionals. During this time, healthcare professionals are exposed to new ethical situations daily due to increased demands on limited resources, confusion related to constantly changing guidelines, redeployment, and the uncertainty of the pandemic's trajectory. These challenges intensify the moral distress nurses routinely experience in their clinical practice (Lake et al., 2021; Silverman et al., 2021). Moral distress arises when one experiences a conflict between what they feel is the ethically correct action and what they are required or capable of doing. A particular event does not cause moral distress; rather it is due to a given situation and the beliefs, values, and wishes of all those involved (Austin et al., 2005; Deschenes, Gagnon, et al., 2020). At the individual level, examples of contributing factors include feeling powerless or inadequate (Prentice et al., 2016), while environmental or system-based factors include the power dynamics among those involved in the situation, lack of resources or support, and conflicts among the healthcare team (Burston & Tucket, 2012; Lamiani et al., 2017). A national survey examining moral distress among intensive care unit (ICU) healthcare professionals showed that perceived hospital supportiveness was significantly negatively associated with levels of moral distress (Dryden-Palmer et al., 2020).

Moral distress can negatively affect the individual experiencing it emotionally, psychologically, spiritually and physically (Austin et al., 2005; Austin, 2012; Dryden-Palmer et al., 2018; Epstein et al., 2020; Rushton et al., 2016). Examples of symptoms that one might experience include heart palpitations, insomnia, nightmares, headaches, fatigue, feelings of powerlessness, depression, anxiety, burnout, and loss of self-worth (Epstein et al., 2020; Henrich et al., 2017; Rushton et al., 2016). The individual experiencing moral distress can develop ineffective coping strategies leading to poor quality patient care and decreased patient

satisfaction, contributing to medication errors (Dekeyser Ganz & Berkovitz, 2012; Henrich et al., 2017; Maiden et al., 2011; Morley et al., 2020). Prentice et al., (2017) found that 72% of healthcare professionals experience moral distress at least once a month. Moral distress negatively affects the retention of healthcare professionals. In a study examining moral distress among healthcare professionals in an intensive care unit, 29% of participants stated they thought about quitting their job (Henrich et al., 2017). Similarly, C. Austin and colleagues (2017) noted that 22% of physicians and 35% of nurses left a position or considered leaving a position due to moral distress. Since Andrew Jameton first defined the concept in 1984, moral distress research has primarily focused on understanding the experiences, causes and effects of moral distress. Few interventional studies have focused on addressing or mitigating moral distress (Deschenes et al., 2021). The crucial next step in moral distress research is developing effective interventions (Burston & Tuckett, 2012; Corley, 2002; Musto et al., 2015).

According to the Medical Research Council (Craig et al., 2018), using a relevant theory is more likely to result in an effective intervention than evidence alone. Relational ethics is a lens that reflects the complexities of daily ethical situations and can further our understanding of morally distressing situations (Deschenes & Kunyk, 2020). This lens assumes ethical challenges occur between people, and therefore ethical situations are not viewed as having one clear outcome (Austin & Kent-Wilkinson, 2019; Bergum & Dossetor, 2020). The foundation of relational ethics is that the space between oneself and the other is where moral action lies. Within this moral space genuine dialogue can occur, and relationships can flourish. This dialogue is the place where relational ethics can be realized, where we can see the other person for who they are, recognize their uniqueness, and appreciate their differences (Bergum, 2013). This ethic has four key elements: mutual respect, engagement, embodied knowledge, and the interdependent

environment (Bergum & Dossetor, 2020). Within open dialogue, each of these elements can be enacted. Moral distress occurs because of a rupture in relationships, and possibly one way to mend this rupture is through relational ethics. Relational ethics can allow us to understand morally distressing situations better and therefore has the potential to minimize the negative effects of moral distress (Deschenes & Kunyk, 2020). Thus, relational ethics was selected in place of a theory because this ethic recognizes that ethical practice is situated within relationships while acknowledging the influence the environment has on guiding ethical action (Deschenes & Kunyk, 2020).

In this paper we explore the third and final phase of the research study, developing an evidence-and-ethic informed intervention to minimize the negative effects of moral distress among pediatric critical care nurses.

## Methods

Informed by the Medical Research Council approach to developing a complex intervention, our team used a three-phase approach to develop an evidence-and-ethic informed moral distress intervention. The development of the moral distress intervention is built on the findings of a scoping review to explore existing moral distress interventions for nurses (Step 1; Deschenes et al., 2021) and a qualitative inquiry exploring pediatric critical care nurses' perspectives on needed elements for a future moral distress intervention (Step 2; Deschenes et al., 2022). Using a systematic process to develop an intervention maximizes the chance an intervention will be feasible, effective, and sustainable while minimizing resource and research waste (O'Cathain, 2019).

### Step 1: Scoping Review

To identify and evaluate the evidence on our topic, (Campbell et al., 2007) we conducted a scoping review using the framework outlined by Levac and colleagues (2010) and Arksey and O'Malley (2005). This review aimed to map out moral distress interventions for nurses providing direct patient care and identify gaps in the existing body of knowledge. Complete details of the methods employed for this review have been detailed in a separate manuscript (Deschenes et al., 2021).

Step 2: Qualitative Description

We used a qualitative description approach (Sandelowski, 2000) to conduct in-depth interviews to identify what pediatric critical care nurses who have experienced moral distress identify as needed interventions to minimize moral distress. The details of the methods, including recruitment, data collection, and data analysis, have been previously reported for this qualitative inquiry (Deschenes et al., 2022).

Step 3: Intervention Development

Findings from steps one and two and the main tenants of relational ethics were used to inform the final suggested intervention. The Template for Intervention Description and Replication (TIDieR checklist; Hoffman et al., 2014) was used to guide the description of the intervention components to ensure thorough reporting, transparency and replicability.

**Results**

Step 1: Scoping Review

Our scoping review revealed few studies examining moral distress interventions, and there is no clear pattern as to which strategies consistently minimize moral distress. The three interventions that had a statistically significant reduction in overall moral distress scores included

an empowerment program (Abbasi et al., 2019), a Freirean-based conscientization intervention directly on moral distress (Bevan & Emerson, 2020) and an educational workshop on moral distress (Molezam et al., 2013). All three of these interventions were focused on a single intervention instead of an intervention bundle. Additionally, all three interventions had at least two sessions, each lasting either 4 or 6 hours, tentatively suggesting that longer interventions may decrease moral distress among nurses (Deschenes et al., 2021). Additionally, three studies observed a statistically significant decrease in one or more *Moral Distress Scale-Revised* (Hamric et al., 2012) survey items but did not note an overall statistically significant reduction in moral distress (Bosshardt et al., 2018; Vaclavik et al., 2018; and Wocial et al., 2017). Bosshardt et al. implemented a policy change allowing nurses to consult palliative care services directly. They noted a statistically significant increase in three survey items and a significant decrease in one item (Bosshardt et al., 2018). Vaclavik and colleagues' intervention was a mindfulness bundle, and a statistically significant decrease in one MDS-R survey item was noted. Lastly, Wocial and colleagues (2017) examined the effects of an interdisciplinary clinical ethics rounds intervention on moral distress. Their results show that this intervention significantly decreases three *Moral Distress Scale-Revised* survey items.

Step 2: Qualitative Description

The findings from our qualitative inquiry identified four broad categories for potential moral distress interventions: increasing support for patients and their families, improving support for nurses, improving patient care communication, and providing education to mitigate moral distress (Deschenes et al., 2022). However, most participants attributed communication challenges to their experiences of moral distress, and these participants recommended

interventions to increase patient care communication among the healthcare team (Deschenes et al., 2022).

Step 3: Intervention Development

During our qualitative study, both units that participants worked on were richly resourced, with the ability to provide one-to-one patient care, stay up to date with best practice guidelines, and numerous strategies to support nurses in their practice. Yet our findings suggest that despite having these strategies in place, study participants experienced moral distress on multiple occasions. We postulate that this may be because these strategies were not driven by relational practice. The following section will provide a detailed description of the novel moral distress intervention following the Template for Intervention Description and Replication (TIDieR) checklist (Hoffman et al., 2014) and the rationale for these details based on stages one and two of this study and relational ethics (Table 5.1). Utilizing this checklist helps to ensure comprehensive and detailed reporting of the intervention to improve replicability of the intervention (Hoffman et al., 2014). An additional benefit of using this checklist is to allow stakeholders to implement the intervention as intended (Hoffman et al., 2014). Developing an intervention is not linear, and refinement of the intervention is to be expected. This intervention should be adjusted in consultation with stakeholders to determine the best fit for the clinical setting and available resources. Once the intervention is finalized for the clinical setting, pilot studies targeting key uncertainties within the design and assessing feasibility should be conducted prior to evaluation (Craig et al., 2018).

Item 1. Brief name: Relational ethics informed interdisciplinary townhall meeting for moral distress

Item 2. Why – the rationale, theory, or goal of the elements essential to intervention:

Inclusion of the rationale, theory or goals that underpin the interdisciplinary townhall meeting help others to understand which aspects of the townhall are foundational and which are discretionary. Using theory to inform the development of an intervention is more likely to result in an effective intervention than using evidence alone (Craig et al., 2018). Moral distress is an ethical issue that occurs because of a rupture in a relationship either with ourselves, a patient (including their family), a healthcare team member, or with the environment. Relational ethics states that dialogue is where ethical action occurs and where people can come together to ask questions and explore solutions. Relational ethics also prioritizes the relationships between individuals, and dialogue to foster relationships should be the central focus of a relational ethics informed moral distress intervention. We used a sequential knowledge development approach to guide the development of this intervention and have detailed our key findings from steps one and two below.

The results from our scoping review (step one) show that only three of the included studies had an overall decrease in moral distress. None of these studies examined an intervention that focused on communication among team members (Deschenes et al., 2020). However, one study included in our review developed a clinical mentoring and ethics support intervention titled Pediatric Ethics and Communication Excellence (PEACE) rounds (Wocial et al., 2017). This intervention focused on interdisciplinary communication regarding ethical and medical aspects of patients with an extended length of stay and was facilitated by a clinical ethicist and the senior intensivist (Wocial et al., 2017). The findings from our review also revealed that interventions

that are singular in focus (e.g., single component versus multiple components) and are longer in duration could help minimize moral distress (Deschenes et al., 2020).

The findings from our qualitative inquiry (step two) reveal that pediatric critical care nurses identify improving patient care communication as one of many possible outcomes needed to be achieved by an intervention to mitigate moral distress. Participants in our study discuss specific venues for this communication to take place, including townhall meetings. However, participants strongly purported that a proactive intervention – rather than a reactionary intervention – that allowed room for interprofessional dialogue prior to them experiencing moral distress was needed. Participants also noted that establishing reliable unit practices (e.g., consistent scheduling of the intervention, a priori criteria of patients discussed) to ensure the intervention is implemented consistently and predictably and that the intervention occurs within a supportive environment is needed (Deschenes et al., 2022).

Item 3 What: The materials used in the townhall:

The description of physical and informational material, which is distinct form procedures, is a critical but often overlooked element. This material includes information given to providers of the intervention during training as well as material given to participants (Hoffman et al., 2014). Providers of the intervention need to understand relational ethics and its key elements to ensure its fidelity (Bellg et al., 2004). This understanding should include recognizing relational ethics is an action ethic that assumes ethical practice occurs within relationships. Relational ethics is pluralistic in nature and recognizes that in ethical situations there is no clear outcome. At the core of this ethic is relationships and to foster relationships open dialogue needs to occur (Bergum & Dossetor, 2020). Within these relationships there is mutual respect including respect

for differences of opinions, values, and experiences, as well as respect for one's embodied knowledge. This ethic requires engagement or intentional action to hear what others are saying while also recognizing the influence the environment has on ethical situations (Bergum & Dossetor, 2020). It is also essential for the intervention providers to recognize how relational ethics can guide us in morally distressing situations. This ethic better reflects the complexities in day-to-day ethical situations and can support nurses to act in a way that does not violate their values (Deschenes & Kunyk, 2020). The intervention providers also need to be given and understand the details of the procedures as described in item four below.

The participants should be provided with pertinent details of each patient's case (including both medical and social aspects that may be relevant to patient care). They should also be provided with supports and contact information to relevant resources should they be come upset during the intervention. Supports could include meeting with a social worker, psychologist, or management depending on what is offered on the unit. This support could be adjusted after consultation with key stakeholders.

Item 4. What are the procedures and processes used in the interdisciplinary townhall:

The intervention procedure should include discussion around patient-related challenges, room for questions, and exploration of possible solutions. All complex patients (as described below) should be discussed in each meeting. The attending physician should start by presenting pertinent details of the patient's case via an oral presentation. Once the case is presented the facilitator should guide participants in a discussion exploring any questions and possible solutions related to patient care. This discussion could be guided by the Relational Ethics Decision-Making Framework (Austin, n.d.; Table 5.2**).** This framework lists four key questions

with numerous sub-questions under each section. The key questions include “What is happening here?” “What are the alternatives for ethical action?” “What is the most fitting thing to do?” and “What happened as the result of our action?” (Austin 2019, p. 110). Once the discussion about a patient is complete, the attending physician should discuss the next patient’s case. This process may need to be adjusted in consultation with stakeholders and after pilot testing the intervention. Once finalized, the procedure should be preserved and well defined to reduce unintended variability of the intervention and improve fidelity (Bellg et al., 2004).

Wocial and colleagues’ (2017) intervention focused on patients with an extended length of stay and communication about challenging medical and ethical aspects of patient care as well as the rationale for treatment interventions if applicable. The results of our qualitative study demonstrate that patients should be included in the intervention based on specific criteria that could indicate a more complicated plan of care for the patient (diagnosis, length of stay or family situations), thus increasing the potential for a morally distressing situation. Participants also suggested having a standardized process to increase the opportunity to discuss potential challenges and ensure that the intervention is implemented in a consistent and predictable manner. Having a standardized approach is not meant to be prescriptive; instead, it is suggested to reduce power dynamics among team members and encourage open dialogue about all aspects of care (Deschenes et al., 2022).

Item 5. Expertise, background of the intervention provider:

We recommend that the intervention should be led by someone trained in facilitating communication (such as a social worker, ethicist, or psychologist) and supported by an attending physician to present and respond to clinical details. This level of training (e.g., degree in which

communication and relationships were a primary focus) was reported as a required element based on the data from our qualitative study (Deschenes et al., 2022). It is essential to have the same facilitator throughout the intervention to maintain and reinforce standards (Bellg et al., 2004). Therefore, having someone other than the physician lead the meetings is crucial because the attending physician will change depending on who is on service. The intervention by Wocial and colleagues (2017) was led by a senior intensivist to help focus the discussion on treatment goals and an ethicist to facilitate discussion surrounding potential ethical conflict. We recommend the attending physician support the facilitator by providing pertinent details of each patient's clinical status (Deschenes et al., 2022).

Item 6. How:

The delivery method of the intervention should be face-to-face meetings. Relational ethics recognizes the ethical space as a necessary component to foster relationships and understand ethical action. This space is where people come together to connect, understand each other through dialogue as well as through unspoken communication (Bergum, 2013; Bergum & Dossetor, 2020) and this connection is best cultivated when sharing the same physical space. However, participants in step two mentioned that zoom meetings are helpful to accommodate busy schedules and encouraged them to attend meetings when they were not on the unit (Deschenes et al., 2022). However, we currently do not recommend this option as organizational/situational privacy and confidentiality concerns would need to be explored thoroughly before considering virtual options.

Item 7. Where:

The townhall intervention must occur in a safe and welcoming space, free from the power structures that are often found within healthcare (Deschenes et al., 2022). This safe space refers to both the physical space and the situational space. The physical space should be large enough to fit everyone comfortably and somewhere secluded to promote confidentiality. Using a relational ethics lens, the environment is a living, ever-changing system that connects us all (Bergum, 2013). It is interdependent, and ethics (including moral distress) cannot be understood by looking at an individual or even a single situation. Instead, we need to examine how the people within the environment interact with one another and create a space for ethical reflection to occur (Bergum & Dossetor, 2020). Relational ethics asks, "could this environment change if attention to the relationship was our primary ethical commitment?" (Bergum and Dossetor, 2020, p. 167). For the intervention to flourish, where all participants can contribute, the immediate environment surrounding the intervention needs to occur in a safe space. Creating a safe space starts with mutual respect, respecting ourselves and the others involved in the situation. Respect includes respecting the knowledge, opinions, values, beliefs and experiences of everyone involved. It also includes respecting differences in power (that are often inherent within the healthcare system) and uses of this power. It is also imperative to respect the embodied knowledge of others because factual knowledge is not enough.

Respect of emotions and feelings is needed during the intervention. Distress is experienced within one's body, and to minimize this distress we need to respect its bodily manifestations and recognize these manifestations as knowledge about the situation that causes distress. This space also requires engagement to move beyond a technical relationship with data and monitors and attempt to look at a situation together. Without engagement the healthcare team can sit in a room together, yet the individuals can feel completely alone and unheard.

Engagement, therefore, is necessary to move toward one another and find an ethical solution. This environment can be created by fostering a sense of community and encouraging open communication that is respected among all participants.

8. When and How much:

We recommend 90-minute weekly meetings but recognize that this may not be feasible for all settings. This would provide sufficient time for multiple voices to be heard and could be adjusted as needed. Meetings with key stakeholders such as the healthcare team, managers, and policymakers are necessary to determine the frequency of the intervention, how it could fit within everyday practice, and explore potential barriers (Craig et al., 2018). Wocial and colleagues held weekly meetings for one year. Participants from our qualitative inquiry suggested weekly updates on patient cases and regular, proactive to discuss patients before potentially distressing situations occur and as they evolve (shortly after admission, before surgeries or procedures, changes in goals of care, etc.; Deschenes et al., 2022).

9. Tailoring:

The MRC complex intervention framework highlights that intervention should be tailored based on the clinical setting and available resources (Craig et al., 2018). However, to ensure fidelity some aspects should not be changed (Bellg et al., 2004) including the materials provided to the townhall facilitators, the procedures, and where the intervention occurs (the safe space).

Items 10. Modifications and 11. and 12: How well:

These items are not applicable at this time but will need to be reported once the intervention is finalized, tested, and evaluated.

**Discussion**

This paper illustrates the multi-phase, evidence-and-ethic informed strategy undertaken to develop a novel moral distress intervention for pediatric critical care nurses. This intervention builds on two previous phases both couched with a relational ethics lens: a rigorous scoping review to identify moral distress interventions and gaps in the research and a qualitative inquiry to understand what pediatric critical care nurses identify as needed interventions to minimize moral distress. We have organized the discussion to explore a) moral distress interventions to increase communication and b) alternative theory-driven moral distress interventions.

We propose proactive, interdisciplinary townhall meetings informed by relational ethics as one possible strategy to minimize the negative effects of moral distress. Recent research has shown that increasing communication among the interdisciplinary team may effectively reduce moral distress (Browning & Cruz, 2018; Morley & Horsburgh, 2021; Wocial et al., 2017). Data from our qualitative study describes the importance of improving patient care communication among the disciplinary team (Deschenes et al., 2022). This study emphasizes the need for a proactive moral distress intervention that occurs before a patient situation becomes complicated.

These findings are in tension with recent moral distress interventional studies. Several studies have implemented interventions to increase patient care communication; however, these studies are often in the form of debriefing sessions. By virtue of a debriefing method, each of these interventions is implemented *after* a morally distressing situation has occurred. Vacklavik et al. (2018) developed a mindfulness bundle that included clinical debriefing sessions after a significant event. While they did not find an overall reduction in *Moral Distress Scale-Revised*

scores, they found a significant reduction in one survey item corresponding to moral distress frequency. In Browning and Cruz's (2018) study examining the effects of a social work-led reflective debriefing intervention, participants reported benefit from discussing situations with colleagues, receiving recognition related to their nursing concerns, and having the opportunity to discuss their emotions. Fontenot and White (2019) conducted a pilot study examining the effects of debriefing following the American Association of Critical Care Nurses model "The 4A's to Rise Above Moral Distress" (AACN, 2005). The researchers found no significant reduction in moral distress pre-intervention compared to post-intervention. However, participants reported subjective benefits by increasing their awareness of moral distress, providing them time to talk with colleagues, and encouraging them to improve their self-care habits (Fontenot & White, 2019). Morley and Horsburgh (2021) describe their five-phase Moral Distress Reflective Debriefing intervention as one designed to respond to morally distressing patient situations. They discuss the importance of a clinical ethicist as a facilitator for this intervention and how this intervention compliments ethics consultation. Although they do not report any empirical data, the researchers demonstrate, through two case studies, that this approach shows promise in mitigating the negative effects of moral distress.

Alternatively, Wocial et al. (2017), as discussed in detail throughout our findings, developed a proactive interdisciplinary ethics rounds intervention. This intervention did not reduce overall moral distress when comparing pre-test to post-test *Moral Distress Scale-Revised* scores. However, this intervention had a statistically significant reduction in three scale items, including "initiate extensive life-saving actions when I think they only prolong death," "work with nurses or other healthcare providers who are not as competent as the patient care requires," and "witness diminished patient care quality due to poor team communication." The intervention

had statistically significant positive effects on patient outcomes, including a change in code status and length of stay (Wocial et al., 2017). Developing a proactive intervention may effectively minimize moral distress by allowing the healthcare team to come together to discuss the situation (including potential ethical action and treatment options), seek clarity, share their feelings, and possibly feel validated.

To our knowledge, no researchers have been guided by relational ethics to shape the development of a moral distress intervention. Several interventional studies for moral distress are atheoretical (e.g., Beumer et al., 2008; Bosshardt et al., 2018; Bruce et al., 2020; Molazem et al., 2013; Saeedi et al., 2019; Wocial et al., 2017) yet as demonstrated in our scoping review (Deschenes et al., 2020) a few have implemented interventions using a variety of theories, lens, or perspectives to varying degrees (Abbasi et al., 2019; Bevan et al., 2020; Meziani et al., 2018). The Medical Research Council states that using a relevant theory in the development of an intervention can increase the likelihood the intervention will be effective than using evidence alone (Craig et al., 2018). Abbasi and colleagues (2019) used a moral distress theory as the foundation to guide the development of their intervention. Nathaniel's Theory of Moral Reckoning in Nursing (Nathaniel, 2006) was developed to understand moral distress and is based on the premise that the nurse experiences moral distress because of irreconcilable conflict between their values and external forces (Nathaniel, 2006). This theory is comprised of three stages: the stage of ease, resolution and reflection. According to Nathaniel, a nurse must deal with the first stage sufficiently, or they will be subjected to moral conflict, leading to moral distress. One limitation of this theory is that it is broad and therefore only touches on its key elements superficially. Additionally, this theory does not suggest that it could inform strategies to develop interventions (Nathaniel, 2006) and its suitability for this application is questionable

(Morley, Field, et al., 2021). Abbasi and colleagues (2019) use this theory to guide the application of their empowerment intervention and explicitly state the theoretical stage that informs the intervention components. This intervention resulted in an overall statistically significant decrease in moral distress among participants (Abbasi et al., 2019).

Other theories researchers used to guide intervention development include nursing theories as well as theories from a variety of disciplines. Meziani et al. (2018) utilized two nursing theories in their reflective practice interventional study, including Watson's Concept of Human Caring (2012) and Johns' model for structured reflection (2006). Watson's Concept of Human Caring is a nursing theory that aims to elucidate the human caring process (Watson, 2012). John's model outlines what being a reflective practitioner involves and how nurses can engage in reflective practice (John, 2006). Johns' model for structured reflection guided the development of the reflective practice intervention, and it is unclear the extent Watson's model was utilized. Disappointingly the results of this intervention did not show a statistically significant difference in pre and post-intervention moral distress (Meziane et al., 2019).

Bevan and colleagues (2020) used Freire's pedagogy of the oppressed (2018) to guide the aims, development and delivery of their conscientization curriculum intervention. This educational theory aims to use everyday experiences to raise the consciousness of an oppressed group to increase their collective power and bring about change (Freire, 2018). The findings from this study show an overall decrease in moral distress (Bevan et al., 2020).

Lastly, we found one additional moral distress interventional study that was not included in our scoping review that used a model to inform the development of their intervention. Browning and Cruz (2018) used several elements of the 3D Model of Debriefing, based on adult learning theory, as the structure for their reflective debriefing intervention. This model aims to

help debriefers facilitate learning to improve practice and focuses on defusing, discovering, and deepening the goals of debriefing (Zigmont et al., 2011). This intervention shows that participants reported benefit from the debriefing sessions (Browning & Cruz, 2018). Vaclavik and colleagues (2018) used the key elements of Felgen's change model (2007) to guide the development of their multipronged mindfulness intervention. This model demonstrates the fundamental aspects of successful, large-scale change: inspiration, infrastructure, education and evidence (Flegen, 2007). This study shows a significant decrease in one Moral Distress Scale-Revised survey item (Vaclavik et al. 2018). Some of the interventional studies guided by theories, lenses, or perspectives as described above, show promising results. However, none of these studies use an ethical lens to develop their intervention. Therefore, relational ethics provides a novel and valuable perspective to guide the development of a moral distress intervention, given the ethical nature of the phenomenon.

**Conclusion**

Based on the results of our multi-phase research, we propose a relational ethics informed proactive townhall meeting as one possible moral distress intervention. Moral distress is a complex ethical experience that occurs when one cannot act in a way that aligns with what they feel is the ethically correct action. This distress occurs due to a break in a relationship and interventions to minimize the negative effects of moral distress are desperately needed. Relational ethics prioritizes relationships in ethical situations and aligns well with moral distress' complex, ethical, and pluralistic nature. Therefore, this ethic can further our understanding of moral distress and potentially minimize its devastating impact on nurses, patients and the healthcare system (Deschenes & Kunyk, 2020). Future studies are needed to finalize this evidence-and-ethic informed intervention in partnership with key stakeholders to determine

feasibility within everyday practice and explore barriers to implementing the intervention (Craig et al., 2018). Once finalized, the intervention will be pilot tested to assess its efficacy. Our evidence-and-ethic informed intervention offers a novel approach to address moral distress and has the potential better support pediatric critical care nurses experiencing the phenomenon.

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Table 5-1 Intervention elements described using the TIDieR checklist

| TIDieR Item | Element supported by relational ethics | Element supported by scoping review (Stage 1) | Element supported by qualitative inquiry (Stage 2) |
|---|---|---|---|
| 1. Brief Name | N/A | N/A | N/A |
| 2. Why<br>• Singular in focus<br>• Communication focused<br>• Interdisciplinary<br>• Townhall format | <br><br>X<br><br>X | <br>X<br>X<br><br>X<br>X | <br><br>X<br><br>X<br>X |
| 3. What: Materials | X | | |
| 4. What: Procedure | X | X | X |
| 5. Who provided | | X | X |
| 6. How | | | X |
| 7. Where | X | | X |
| 8. When and how much | | X | X |
| 9. Tailoring* | | | |
| 10. Modifications | N/A** | N/A** | N/A** |
| 11. How well: Planned | N/A** | N/A** | N/A** |
| 12. How well: Actual | N/A** | N/A** | N/A** |

* Cells left black as tailoring is based on Bellg et al., 2004 and Craig et al., 2018

**Not applicable at this time. Clarity will be sought with future research.

Table 5-2 A Relational Ethics Decision-Making Framework

| Key Questions |
| --- |
| 1. What is happening here?<br>2. What are the alternatives for ethical action?<br>3. What is the most fitting thing to do?<br>4. What happened as the result of our action? |
| Question 1: What is happening here?<br>• What are the ethical questions? Their context?<br>• Who is involved? (Who are the moral agents?) What are their commitments to one another?<br>• What further information do we need?<br>• Are there legal, organizational, professional, cultural, religious, or any other aspect ot consider? Are values in conflict?<br>• What resources do we have? Need?<br>• Patient and family resources (e.g., personal directives)?<br>• Health care resources: (e.g., access to home care)?<br>• Ethics resources: principles, precedents, codes, policies, guidelines, ethicists/ethics committees, etc.?<br>• To what, in particular do we need to attend? |
| Question 2: What are the alternatives for ethical action?<br>• What are the consequences for each alternative?<br>• What might constrain ethical action? What, if anything, makes me or others uncomfortable in regard to a potential action? |

| |
|---|
| • Remember: refraining from making a decision is still a decision. |
| Question 3: What is the most fitting thing to do?<br>• What is the best way to carry out the decision (or plan)?<br>• Who is affected? Who needs to be involved?<br>• How many disparate views be bridged? |
| Take Action |
| Question 4: What happened as the result of our action?<br>• What concerns remain?<br>• Is anyone distressed about the result?<br>• Is further action desirable?<br>• Do we need to address systemic factors that gave rise to the situation?<br>• Would we act in the same way again?<br>• What did we learn? |

# Chapter 6 Discussion and Conclusion

## Overview of Findings

The aim of my dissertation was to develop an intervention to mitigate the negative effects of moral distress for pediatric critical care nurses. There were three key knowledge gaps in the area of moral distress that were highlighted through this research. First, there were limited interventional studies on moral distress among nurses. This lack of evidence identified how little is known about effective interventions to mitigate the negative effects of moral distress. Second, there was an apparent lack of nurses' voices identifying what they needed to minimize their moral distress. Third, there is a lack research describing how to develop a moral distress intervention. My doctoral research is foundational work necessary to develop effective and validated moral distress interventions that will improve the working lives of nurses. In this final chapter of my dissertation, I describe how each of my four dissertation papers has advanced our knowledge of moral distress and propose the next steps for future work.

## Implications for Research and Practice

This study makes a substantial contribution to moral distress research. Nurses' viewpoints are explored through this work, and their needs for moral distress intervention are identified. This research has the potential to improve the working lives of nurses.

### *Theoretical Exploration* (Chapter 2, Paper 1)

This paper was the first to explore the experience of moral distress through a relational ethics lens. Through its core elements (mutual respect, engagement, embodied knowledge, and the interdependent environment), I explored how relational ethics could increase our understanding of moral distress. I stated that nurses need an ethic that better reflects the complexities within day-to-day ethical situations to help deepen their understanding of moral

distress. This ethic prioritizes relationships and the relational space, the space among individuals, is where ethics occurs. Moral distress also occurs in this space due to a rupture in relationships. Furthermore, relational ethics offers a necessary framework to examine moral distress. It allows individuals to realize their interconnectedness with one another and that the actions of one impact and affect the community surrounding them. I recommend that this ethic should be used as the theoretical foundation to guide the development of moral distress interventions. This approach will further our understanding of moral distress and has the potential to mitigate the negative effects of the phenomenon.

***Literature Review* (Chapter 3, Paper 2)**

This scoping review was one of the first to synthesize moral distress interventional studies. This review demonstrated that there are limited interventional studies on moral distress among nurses working at the bedside. Given the prevalence of moral distress and its devastating effects on nurses (Austin et al., 2017; Colville et al., 2019; Henrich et al., 2017), these results were surprising. Our study established that there was no clear pattern as to which interventions consistently minimized the effects of moral distress among nurses. However, the only three studies that noted a statistically significant decrease in overall moral distress scores provided interventions with a minimum of two sessions each, and each session lasting at least 4 hours per session (Abbasi et al., 2019; Bevan & Emerson, 2020; Molazem et al., 2013). These findings tentatively suggested that longer interventions may decrease moral distress scores.

Our findings showed that 70% of included studies implemented interventions that solely focused on evoking change within the individual nurse. In contrast, other studies were either multifocal, with effects on both the individual and the unit/system or focused only on changes within the unit. Within the moral distress, literature tension exists on where interventions should

focus. Some researchers suggest that interventions should focus on the work environment (Austin, 2016; Lutzen & Kvist, 2012; Pendry, 2007), while other researchers note that empowering nurses may mitigate the negative effects of moral distress (Rushton, 2016; Rushton et al., 2016). Similarly, one national survey identified that interventions should be tailored to the individual (Dryden-Palmer et al., 2020). We suggested that interventions focused on both the individual and organizational levels should be developed due to the limited existing moral distress interventions. We also recommend two changes in how the outcomes are measured for moral distress interventions. First, we suggested a standardized system for reporting the results of the *Moral Distress Scale-Revised* (MDS-R, Hamric et al., 2012). In our review, 70% of included studies measured moral distress using the MDS-R, yet different metrics were reported, and therefore we were unable to compare results directly. A standardized reporting system would allow studies using this measurement tool to be compared. Second, our review also highlighted a gap in the potential outcomes of these interventions. Only one study (Wocial et al., 2017) measured outcomes other than moral distress. While Wocial and colleagues (2017) found a statistically significant decrease in specific moral distress survey items, they also found a statistically significant decrease in patients' length of stay, an increase in code status changes to 'Do Not Resuscitate' and an increase in nurses' ability to communicate with other healthcare professionals and patients. Therefore, we also suggested that future interventional studies need to measure more than moral distress to identify the potential range of its effects.

### ***Qualitative Description*** **(Chapter 4, Paper 3)**

The next step in my doctoral research was to understand what pediatric critical care nurses identified as a needed intervention or intervention attributes to minimize their moral distress. For this research phase I conducted a qualitative description study, which was the first

study that asked nurses themselves what they need for their moral distress. Our findings revealed that potential moral distress interventions should focus on interventions that increase support for patients and their families, improve support for nurses, improve patient care communication and provide education on moral distress and communication strategies.

One major finding from our study was that most participants stated that their moral distress was caused in part due to insufficient patient care communication and therefore expressed an urgent need for strategies to improve communication. Although opportunities to communicate among the team were present in the units at the time of this study, participants specifically identified a need for a standardized process with a trained facilitator to foster a safe environment for effective patient care communication to take place. Our findings are echoed in the moral distress literature, where communication challenges have been identified as a contributing factor to moral distress (Browning & Cruz, 2018; Henrich et al., 2016; Larson et al., 2017; Morley, Ives, et al., 2021).

Our study also noted that limited support for patients and their families contributed to nurses' moral distress. Participants stated that increasing support for patients and their families through more immediate referrals to social work, palliative care, or spiritual care, for example, could improve the patients' quality of life during their stay in the ICU and therefore alleviate nurses' moral distress. This novel finding is not well explored in the moral distress literature and needs to be explored in future research.

### ***Integration of Results to Develop an Intervention*** **(Chapter 5, Paper 4)**

There were some parallels in the findings from our theoretical exploration, literature review, and qualitative study that guided our development of a moral distress intervention. Our results suggested improving communication among the healthcare team should be explored.

Specifically, relational ethics prioritizes relationships, and dialogue is where relationships happen, and ethical action can occur (Bergum & Dossetor, 2020). The results from our literature review did not identify a clear pattern as to which moral distress interventions are effective. However, our findings tentatively show that interventions longer in duration and ones with a single focus could effectively mitigate the negative effects of moral distress. Lastly, the results from our qualitative study identified the need for a proactive standardized townhall meeting as a potential strategy to minimize nurses' moral distress. These findings are echoed in the literature. Numerous research studies have shown that improving team communication could effectively minimize moral distress (Browning & Cruz, 2018; Morley & Horsburgh, 2021; Wocial et al., 2016). While many strategies or combinations of strategies could be implemented, we suggested that a proactive standardized moral distress intervention, informed by relational ethics, should be developed. This intervention is outlined following the TIDieR checklist to ensure comprehensive reporting that includes the rationale for each item of the intervention (Hoffman et al., 2014). Lastly, we briefly described the steps needed to finalize the intervention, including meetings with key stakeholders to discuss intervention details and explore the barriers and feasibility of the intervention.

**Strengths and Limitations**

One strength of my doctoral research is the philosophical and methodological alignment. Using a qualitative description approach not only aligned with the pluralistic epistemological approach often valued within nursing research, but qualitative description also aligned with relational ethics.

Paper 1 was the first paper to explore moral distress using a relational ethics lens and offered a new perspective to view the phenomenon from. Therefore, this paper advances our

knowledge of moral distress. The scoping review (paper 2) was one of the first reviews examining effective interventions for moral distress. In the scoping review there were limited included studies with low methodological quality, and we only included studies published in English. However, this study demonstrates the lack of effective interventional studies on moral distress for nurses. In the qualitative study (paper 3), a unique perspective exploring nurses' views on what interventions are needed within pediatric critical care to minimize their moral distress was sought. Data from the interviews revealed numerous possible moral distress interventions. However, there is a lack of transferability due to the nature of qualitative work. Recruitment was open to all nurses working in the two pediatric critical care units; yet, we were only able to recruit female participants with less than 12 years of experience. This may further limit the transferability of the results. Nurse participants self-reported their moral distress experiences, and therefore recall bias may affect the results. Additionally, participants in this study identified needed strategies based on their experiences working within two pediatric critical care units in Alberta. These needs may not be the same in other settings or within other hospitals across the province, country, or internationally. In paper 4, we develop an evidence-and-ethic informed intervention. This is a novel intervention based on sequential knowledge development. I have secured a postdoctoral position to finalize, pilot test, and evaluate the intervention.

**Next Steps**

To develop and implement an effective moral distress intervention two significant next steps need to occur 1) finalize the details of the intervention, and 2) pilot test and evaluate the intervention. First, to identify intervention details, researchers need to consider that moral distress is a relational phenomenon involving the views and experiences of all of those involved

in the situation. Therefore, future research needs to work with key stakeholders (e.g., managers, educators, policymakers, and end-users) to determine its feasibility within everyday practice and explore any barriers to implementing the intervention (Craig et al., 2018). Once the intervention details are finalized, pilot testing and evaluating the intervention are necessary to see if the desired outcomes are achieved (reducing moral distress among nurses and other predetermined outcomes). I will complete both research steps described in my future postdoctoral position, which I have secured within the Department of Critical Care Medicine, Faculty of Medicine and Dentistry, University of Alberta. This position will allow me to continue to develop knowledge on moral distress and interventional development, help initiate my academic career, and, most importantly, make a significant positive impact on the working lives of nurses and other healthcare professionals. Beyond my postdoctoral position, my program of research could focus on continuing to develop effective moral distress interventions.

**Conclusion**

Throughout my dissertation, I have generated a comprehensive understanding of moral distress and have significantly contributed to the field of knowledge. I have made theory and research advancements related to moral distress that substantively contribute to nursing. My multiphase research study filled knowledge gaps on moral distress and developed foundational knowledge needed to improve the working lives of nurses related to moral distress. My theoretical paper was the first to examine moral distress through the lens of relational ethics. My literature review was the first that synthesized moral distress interventions among nurses. We found no clear pattern as to what type of intervention would minimize nurses' moral distress. Due to this lack of guidance surrounding effective moral distress interventions, I conducted a qualitative study to explore nurses' perspectives on potential moral distress interventions. To

further understand how a moral distress intervention should be developed, I utilized a sequential knowledge development approach, bringing in the findings from my theoretical exploration and the first two phases of my research. This research approach maximizes the chance the proposed moral distress intervention will be effective, feasible and sustainable. My doctoral research is the foundational research needed to develop effective moral distress interventions. Therefore, this work has the potential to minimize the negative effects of moral distress and improve the working lives of nurses.

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## Appendix A: Study Information Letter

Study Title: Moral Distress in the PICU/PCICU: Development of a Nursing Intervention


| Student Co-Investigator: | Supervisors: |
|---|---|
| Sadie Deschenes, MN RN<br>Level 3, Edmonton Clinic Health Academy<br>University of Alberta<br>Edmonton, AB T6G 1C9<br>sdeschen@ualberta.ca | Principal Investigator:<br>Diane Kunyk, PhD RN<br>3-112 Edmonton Clinic Health Academy<br>University of Alberta<br>Edmonton, AB T6G 1C9<br>Diane.kunyk@ualberta.ca<br><br>Co-Investigator:<br>Shannon Scott, PhD RN<br>5-187 Edmonton Clinic Health Academy<br>University of Alberta<br>Edmonton, AB T6G 1C9<br>Shannon.scott@ualberta.ca |


Why am I being asked to take part in this research study?
You are being asked to participate in this study because you are an RN who works in the PICU or PCICU and has experienced moral distress. Moral distress occurs when a nurse is unable to act according to their moral judgment due to workplace (e.g., pace of work, available resources) or personal (e.g., professional role, work responsibilities) factors. This research is being done to develop an intervention to minimize the negative effects of moral distress.

What is this study about?
The purpose of this study is to understand what intervention nurses feel is needed to support them through morally distressing situations better. This information will be used to inform the development of an intervention to minimize the negative effects of moral distress. The results of this study will contribute to my PhD dissertation.

What am I being asked to do?
You are being asked to participate in this research study by sharing your professional opinion on what you think is needed in the PICU/PCICU to mitigate moral distress. Interview questions will cover topics surrounding your experiences of moral distress and what you think could be done in your workplace to manage moral distress. Your participation is voluntary. You are being asked to participate in an interview that will take place at a time and location that is convenient for you. The interview will take no longer than 60 minutes. This interview will be audiotaped, transcribed, and identifying information removed following transcription. This is to assist the researchers to obtain information accurately. This recording can be stopped at any time. You may also refuse to answer any questions, stop the interview, and/or withdraw from the study at any time.

What are the potential benefits?

The potential future benefit to you is that this intervention may be implemented within the PICU/PCICU in hopes of minimizing the negative effects of moral distress. However, you may not receive any benefit from being in this research study.

What are the potential risks and discomforts?
There are minimal foreseeable risks with participating in this study. However, it is not possible to know all of the risks that may happen in a study. The researchers have taken all reasonable safeguards to minimize any known risks to study participants. One potential risk includes becoming emotionally distressed during the interview. Should you become emotionally distressed, there are resources available to you. The study team has made arrangements for participants to contact pastoral care services. Participants can also contact the PICU Critical Incident Stress Management team and see the registered psychologist if needed. Additionally, participants can contact Employee and Family Assistance Program at 1-877-273-3134 or by visiting homeweb.ca. More information about this program is available through insight.

Do I have to take part in this study?
Being in this study is your choice. If you decide to participate in the study, you can change your mind at any point during the interview without explanation or within two weeks after the interview is complete. However, two weeks after the interview occurs, your data will be anonymized, and it will not be able to be retracted.

How will my information be kept private?
Your privacy is highly important. All the information shared will be kept confidential. The information will be stored in a secured area only accessible to the study team. Your name and any identifying information will not be linked. Your name will never be used in any publications or presentations. Direct quotes may be used, but they will be presented in a manner in which identifying information will be removed. Any information gathered in this study may be looked at in the future to assist the study team in answering related research questions. If this occurs, ethics approval will be required at that time.

All situations related to abuse, harm to self or others, or dangerous care will be discussed among the study team to determine the appropriate next steps.

Additionally, there may be an opportunity for you to provide feedback on the intervention. This may include viewing the intervention online and completing a survey. Should you wish to be contacted in the future for further details about this, please let the investigator know.

What if I have questions?
If you have any questions or concerns regarding this study at any time, please contact:

Dr. Diane Kunyk, Diane.kunyk@ualberta.ca, 780-492-4338
Dr. Shannon Scott, Shannon.scott@ualberta.ca, 780-492-1037

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at reoffice@ualberta.ca or 780-492-2615. This office has no affiliation with the study investigator.

## Appendix B: Draft Interview Guide

Study Title: Moral Distress in the PICU/PCICU: Development of a Nursing Intervention

1. Tell me about your work.

2. Tell me about your overall experience working in the PICU/PCICU.

3. What is your current understanding of MD?
    a. Can you share a situation where you experienced MD?
    b. How often would you say you experience MD?

4. What do you think the contributing factors were for the situation(s) you described?

5. Can you tell me about a situation where you thought MD was handled well at work?

6. What about a situation when it was not handled well?

7. What would have been helpful for you to better manage that morally distressing situation?

8. What would you tell nurses just starting in the PICU/PCICU about MD and how to handle it?

9. What do you think could help nurses manage MD?

10. What could be done in your workplace to manage MD? (presentation, rounds, team meetings, etc.)

11. Is there anything else that you would like to share?

## Appendix C: Demographic questionnaire

Study Title: Moral Distress in the PICU/PCICU: Development of a Nursing Intervention

Demographic questions: Please select the best answer.

1. Do you work in the PICU/PCICU?
   -PICU
   -PCICU
   -Both
   -Float pool

2. What is your gender?
   -Male
   -Female
   -Other
   -Prefer not to say

3. What is your age?
   -20-29 years
   -30-39 years
   -40-49 years
   -50-59 years
   -60 years and older
   -Prefer not to say

4. What is your highest level of education?

5. How many years have you been practicing as an RN?

6. How many years have you worked in the PICU/PCICU?