Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

by

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Abstract

Objective: To increase our understanding of moral distress experienced by nurse practitioners in the continuing care setting

Design: This qualitative study employed an interpretive description approach in which participants in a major urban center in Western Canada were interviewed about their experiences of moral distress.

Participants: The study consisted of a small sample of six nurse practitioners that practiced in the continuing care setting during the time of recruitment. Inclusion criteria ensured potential participants had practiced as a nurse practitioner for a minimum of one year, had practiced in the continuing care setting for a minimum of six months, and were able to speak English.

Methods: Semi-structured face-to-face interviews were conducted and recorded with each of the participants. Transcriptions were imported into QSR International NVivo Version 11 for thematic analysis of the participants' experiences of moral distress, including contributing factors, and methods to address these experiences.

Ethical Considerations: Ethical approval was obtained from the Research Ethics Board at the University of Alberta prior to commencement of the study.

Findings: This study provided confirmation that nurse practitioners in continuing care experience moral distress. The data presented five themes related to the tensions they identified in their descriptions of their experience. The themes were patients, perceptions, physicians, palliation, and policies. It was found that nurse practitioner experience of moral distress was similar to that of the registered nursing population, although the contributing factors had perhaps a more pronounced impact because of the advanced level of independence and the persistent role issues in advanced practice.

Conclusion: Moral distress is a substantial issue for nurse practitioner practice in the continuing care setting. Further research is required in the continuing care setting in addition to other settings, to determine as to whether the experience of moral distress is limited to the profession, practice setting, both, or neither. It is imperative that the experience and contributing factors of moral distress be addressed, and that strategies for cohesiveness among key stakeholders in continuing care be developed in order to decrease the negative experiences of nurse practitioners, and prevent them from leaving the profession.

Preface

This thesis is an original work by Vanessa Ritchie. The research project, of which the thesis is a component of, received ethics approval by the University of Alberta Research Ethics Board, "Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting" ID Pro00068508, January 6, 2017.

The study design, data collection, and data analysis was led by Vanessa Ritchie, with assistance and supervision by Dr. Tammy O'Rourke and Dr. Sarah Stahlke. The manuscript provided in Chapter 2 will be submitted to *Nursing Ethics* to be considered for publication and will be co-authored by Vanessa Ritchie, Dr. Tammy O'Rourke, and Dr. Sarah Stahlke. Vanessa Ritchie was responsible for data collection, data analysis, and development of the manuscript. Dr. Tammy O'Rourke and Dr. Sarah Stahlke assisted both in development of the conceptual framework and thesis edits.

Dedication

To my loving husband Curtis, who so patiently waited as I pursued my dreams and always believed in me when I did not.

To my parents who so graciously provided a roof over my head, food in my bag, and support when I needed it the most. I couldn't have made it without the two of you.

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Last, but certainly not least, thank you to all of my family and friends who have supported me over the past two and a half years as I pursued my Master's degree. To my husband who endured our time apart and constantly reinforced my capabilities during times of my own self-doubt. To my parents who have always encouraged me to pursue my dreams. To my friends, new and old, who have supported and encouraged me through this journey. I appreciate all of you more than I could ever say, and I cannot wait to see what the future holds in store for all of us.

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Chapter One
Introduction

This study explores the experiences of moral distress in nurse practitioners within the continuing care setting. The Canadian population is continuing to age, and as such, the strain on the healthcare system is increasing (Canadian Medical Association [CMA] 2016). Statistics Canada has projected that seniors over the age of 65 will encompass 25% of the Canadian population by 2056 (Statistics Canada, 2014). Nurse practitioners may play a fundamental role in alleviating some of this stress on the healthcare system through their role that aims to optimize the health and wellbeing of individuals that receive care in their own private home, supportive living, or in long-term facilities; also known as continuing care settings (Alberta Health Services, 2016). Unfortunately, nurse practitioners are only now beginning to gain momentum in Canada, especially in the province of Alberta. As such, there is potential for these individuals to encounter situations related to a variety of contributing factors that may cause them to experience moral distress.

Unfortunately, there is a significant lack of literature on moral distress in the nurse practitioner population. Rather, research has been focused largely on the general nursing population, specifically on registered nurses in a variety of acute care settings. This study aims to gain a better understanding of the experience of moral distress in the nurse practitioner population in the continuing care setting, as a means to understand the similarities and variances of experiences and contributing factors from that of the general nursing population. Nurse practitioners have the ability to play a pivotal role in the healthcare system in influencing both individual and population health through increased accessibility, education, and provision of high quality care (Archibald & Fraser, 2012). By gaining a better understanding of their experience, we can acknowledge and potentially identify tools and solutions to alleviating moral

distress. It is imperative that we gain this understanding to prevent this group of practitioners persistently experiencing these situations of moral distress, and ideally prevent them from the currently known negative outcomes of moral distress, with the most severe case being of practitioners leaving the profession altogether.

Organization of the Thesis

This thesis follows a paper-based format. The first chapter is an introduction to the thesis and includes background information, research questions, significance, and methods. A short literature review will also be provided within this chapter as there was limited literature on this topic. This literature review was completed prior to commencement of the research study and has assisted in identifying gaps in the present literature and provided significance for the study. The second chapter will include a publishable manuscript that will contain pertinent findings of the research study. The concluding chapter of the thesis will include discussion of the research findings in relation to current literature and will include implications for current healthcare professionals, including nurse practitioners, nursing managers, and physicians. This chapter will also identify limitations of the study and will provide recommendations for future research. Conclusion of the chapters will be followed by references and various appendices that include instruments created and utilized during this research study.

Background

The profession of nursing has been evolving for many decades, progressing from the initial role of a subordinate caregiver, to the hopeful practitioner with future visions of autonomy. As the profession evolves, nursing's scope of practice increases in diversity, and areas of practice span multiple environments. The nursing role is continuing to expand and change, and so does the Canadian population. Canadians are aging, and as such, their health is becoming

increasingly complex, requiring more assistance in preventing, maintaining, and treating illness (Archibald & Fraser, 2013). Our healthcare system is stressed with the increase in patient needs and lack of available resources. Nurses have been and continue to be the frontline healthcare professionals for many of these patients and their families, and therefore are exposed to a number of different, as well as difficult situations. These difficult situations can result in negative feelings including uncertainty and discomfort and result in experiences of moral distress (Corley, 2002; Edwards, McClement, & Read 2013).

Nurse practitioners are unique healthcare professionals with advanced practice roles that offer an important solution to Canada's stressed healthcare system. With the aging population comes a need for more suitable services and accommodations (CMA, 2016). The current Canadian healthcare system was initially structured to meet the acute care needs of a relatively young, healthy population (CMA, 2016). However, the aging population requires a variant of care that places a demand for healthcare reform (CMA, 2016). 75-80% of seniors have reported having at least one chronic condition, of which require ongoing utilization of healthcare services (Statistics Canada, 2014). Nurse practitioners may be optimal healthcare providers to address the needs of the aging population, especially in their ability to provide high quality chronic disease management (Canadian Nurses Association [CNA], 2016). Unfortunately, the evolving scope of practice and complex integration into the healthcare system may leave nurse practitioners experiencing difficult situations, potentially leading to experiences of moral distress. Current research on the phenomenon of moral distress has largely been focused on the nursing community in general, specifically on registered nurses in environments of acute care, elective abortion, palliative care, and mental health (Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). It is important that we identify the factors contributing to moral distress in this population of

registered nurses as insight to these factors may allow us as researchers to predict and address these issues as they pertain to nurse practitioners. Nurse practitioner practice may be invaluable in Canada's healthcare reform, and moral distress may be a potential barrier to its optimal utilization.

Moral distress. The phenomenon of moral distress is one that is receiving increasing attention in the literature. To better understand this phenomenon, it is imperative to distinguish the defining principles of other ethical problems, including moral uncertainty, moral dilemma, and moral outrage. Moral uncertainty arises when an individual is unsure of what the moral problem is or what the moral values and principles are that apply to a given situation (Jameton, 1984). In contrast, moral dilemma posits that an individual is aware of the problem, but there are two or more conflicting values with no solution to appease each sufficiently (Jameton, 1993). A third term, moral outrage, was discussed as an additional ethical issue, that strongly relates to moral distress (Jameton, 1993). Moral outrage describes when nurses are opposed to actions performed by others that they believe to be immoral, but are powerless to stop it, and as a result, experience negative emotions that are similar to moral distress (Wilkinson, 1987).

Jameton (1984) initially defined moral distress as when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). He witnessed this phenomenon directly while observing the constraints that nursing students endured during a clinical practicum (Jameton, 1984). While discussing the problem of moral distress, Jameton (1984) further proposed five questions to consider an individual's participation in wrongdoing. These questions focused on the degree of harm, frequency of occurrence, the nurse's role and attitude in participation, and the possibility of preventing harm (Edwards, et al., 2013). Moral distress can occur when initially exposed to a distressing situation or can be more

reactive, leaving moral residue, when an individual is unable to act in such a situation (Jameton, 1993; Pauly, Varcoe, & Storch, 2012). Over time, researchers have noted various factors and outcomes in the variable experiences of moral distress. Nathaniel (2006) synthesized many of these findings into the following definition which will be used for the purpose of this study:

> Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong. (p. 421)

Over the past 30 years, the definition of moral distress has been examined and redefined by multiple ethicists and researchers. The experience is said to be unique to both the individual and situation (i.e. a certain individual may experience moral distress given a specific situation while others may not, and others may experience distress given a certain situation when this particular individual may not (Epstein & Delgado, 2010). As previously mentioned, research regarding moral distress has largely been conducted in the profession of nursing. Contributing factors impacting this specific population have been widely researched on a conceptual level, and have been shown to be comprised of both internal and external contributing factors (Burston & Tuckett, 2012; Varcoe, Pauly, Webster, & Storch, 2012; Varcoe et al., 2012).

Internal factors. Internal factors encompass issues that are directly related to the individual on a personal level. The experience of moral distress has been said to be grounded in the individual (Burston & Tuckett, 2012). As such, factors influencing the experience have been linked to an individual's worldview, experience, and values (Burston & Tuckett, 2012). Creswell (2014) defines worldview as basic beliefs that an individual uses to assist in guiding action.

Nurses are viewed as moral agents and, as such, their actions are grounded in moral standards, making each action performed "fundamentally ethical" (Atabay, Çangarli, & Penbek, 2015; Austin, 2012; Burston & Tuckett, 2012; Corley, 2002, p. 637; Lützen, Cronqvist, Magnusson, & Andersson, 2003; Varcoe et al., 2004). Nurses' worldviews often reflect their perspective of standards of care, ethical action, and their level of moral sensitivity (Burston & Tuckett, 2012). Such viewpoints often relate directly to an individual's character, including their own personal values. For example, a nurse who values privacy and confidentiality may find it morally distressing to provide care in a hospital hallway when there is no other space available, allowing a patient's own privacy, as well as dignity to be affected.

In addition to worldviews and values affecting an individual's moral sensitivity of specific situations, a nurse's experience may also play a vital role in the way in which an individual encounters a given incident. Studies have shown that nurses with less experience are at higher risks for experiencing moral distress, as their lack of previous exposure impedes their ability to make sound ethical decisions (Austin, 2012; Burston & Tuckett, 2012; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014). Nurses with more experience may have developed the tools and abilities to accommodate uneasy situations. Rather than experiencing moral distress in these situations, these individuals may appear to continuously cope, building up feelings in which we feel like we are continuously compromising ourselves, an experience known as moral residue (Burston & Tuckett, 2012; Epstein & Delgado, 2010; Webster, & Baylis, 2000; Wilkinson, 1987). The repetition of exposure to similar situations begins to have less of an impact on the nurse regarding the outcome of a patient, rather holds a sense of "here we go again," leading to feelings of futility and resulting in the build-up of moral residue (Epstein & Delgado, 2010).

A third internal factor that contributes to incidences of moral distress relates to an individual's level of practice knowledge and their resulting confidence. Nurses that lack confidence in their ability, level of knowledge, and practice may feel uncomfortable making certain decisions in morally distressing situations (Varcoe et al., 2012). As well, this lack of confidence may prevent them from questioning or voicing their concerns regarding actions and/or decisions of another healthcare practitioner (Burston & Tuckett, 2012; Hamric, Davis & Childress, 2006; Varcoe et al., 2004). These situations while initially morally distressing, specifically result in moral outrage, and increase their level of moral residue (Burston & Tuckett, 2012; Hamric, et al., 2006).

External factors. External factors refer to key contributors that are external to the individual perspective. These factors may include issues that arise specifically in the site of practice, or are as a result of decisions made from an organizational perspective. The literature highlights a variety of contributing factors relating to the working environment that influence the experience of moral distress. Two factors of significance that have been identified are appropriate staffing levels and lack of appropriate resources (Austin, 2012; Burston & Tuckett, 2012; Corley, 2002; Pijil-Zieber et al., 2008; Sauerland et al, 2014; Sundin-Huard & Fahy, 1999).

Staffing as a contributing factor plays a two-part role. First, insufficient staffing places increased stress on nurses, as the limitation of time to perform necessary tasks may cause them to make decisions that limits which patients are attended to and the tasks that are performed (Austin, 2012; Burston & Tuckett, 2012; Corley 2002; Pijl-Zieber et al., 2008; Wall, Austin, & Garros, 2016; Wilkinson, 1987). This increase in stress may cause nurses to develop an indifference to their patients, and rather than seeing them as individuals they care for, they are viewed as an

unmanageable number of tasks (Pijl-Zieber et al., 2008). Further, this increased stress on their scope and expectation of practice may cause them to feel distressed regarding the level and quality of care they are providing, relating back to their worldview perspective on standards of care (Austin, 2012; Burston & Tuckett, 2012; Corley, 2002; Pijl-Zieber et al., 2008).

Second, the limitations in staffing levels may cause training and mentorship to be reduced due to the high needs and shortage of staff on the unit (Austin, 2012; Burston & Tuckett, 2012; Pijl-Zieber et al., 2008). New nurses, or those with less experience, may feel that they are expected to perform beyond their capabilities, which not only places patients at potential risk, but causes other nurses and the nurses themselves to question their competence in practice (Austin, 2012).

Resources also play a pivotal role in the experience of moral distress. Often, a lack of resources leaves nurses feeling distressed as it impacts the ability of a nurse to provide appropriate and adequate care for their patients (Austin, 2012; Green & Jeffers, 2006). Alternatively, nurses have found it morally distressing when participating in the utilization of resources during certain situations that they deem futile or counter a patient's wishes, especially regarding end of life care (Austin, 2012; Green & Jeffers, 2006; Pijl-Zieber, 2008; Russell, 2012; Varcoe et al., 2012; Wall et al., 2016). Studies have demonstrated that nurses are not only distressed by a lack of physical resources needed to provide necessary care, but also distressed when resources relate to bed availability or allocation. Nurses are morally distressed when they know patients require more care, but there is a lack of accessibility to specific resources (Brazil, Kassalainen, Ploeg, & Marshall, 2010).

An additional contributing factor to the experience of moral distress relates to ethical climate. The term ethical climate describes the perceptions of what is considered correct ethical behavior and the idea of how ethical issues should be addressed within an organization (Atabay,

et al., 2015). Nurses have identified the power struggle between frontline staff and management when it comes to discussing ethical concerns (Humphries & Woods, 2016; Wall & Austin, 2008). Humphries & Woods (2016) identified that nurses felt that managers effectively "shut down any dialogue" when ethical concerns were voiced by either attributing their concerns to their individual downfalls as a nurse, or by giving negative feedback that reflects the nurse's inability to be an effective member of the team (p. 272). In these circumstances, nurses often felt unsupported by their managers as they experienced these situations, leaving them feeling helpless and powerless, with the potential to impact patient safety (Humphries & Wood, 2016).

To further the argument regarding helplessness and powerlessness, the literature also suggests that nurses experience moral distress due to their relationship with other healthcare professionals, specifically physicians. Often, nurses feel that they have no ability to influence medical decisions, especially those relating to patient pain and suffering (Austin, 2012; Humphries & Wood, 2016; Sundin-Huard, & Fahy, 1999). Additionally, nurses feel powerless to prevent premature transfer of patients to other units or to discharge them home before they are in a stable condition (Humphries & Wood, 2016).

Factors that may arise from a broader organizational standpoint may include economic components, facility policy, and governing regulations (Burston & Tuckett, 2012; Wall et al., 2016). Economic components are often associated with improving efficiency, cost-containment, and allocation of resources, thus influencing the environmental factors of staffing and accessibility of appropriate resources (Austin, 2012; Edwards et al., 2013). Practices and policies designed to meet efficiency standards may oppose nursing's ethical and practice values, including maintenance of high quality standards of care (Austin, 2012). Austin (2012) used McDonalds to represent the corporate move to efficiency; how this drive to control the

"efficiency, calculability, predictability, and control" of the healthcare system has led to nurses feeling dehumanized and morally distressed as their actions are too precise and controlled by the system (p. 35).

Organizational policy on certain aspects of practice may also be influenced by third party contributors, specifically where specificity of resource use is concerned (Burston & Tuckett, 2012). Resources that may not be high quality are sometimes utilized in care as companies may play a substantial role in organizational funding models (Burston & Tuckett, 2012). The use of subpar resources may cause nurses to feel morally distressed as it relates back to their worldview, and more specifically, ethical practice and standards of care. Although these seem to stem from broad external factors, it is clear to see that there is movement of these factors through the different levels of contributors that influence the experience of moral distress.

Consequences. Persistent experiences causing moral distress, which lead to increased occurrences of moral residue, have been associated with a high incidence of negative consequences. Similar to the contributing factors, these consequences span varying levels that are both internal and external to the individual. At the individual level, consequences of moral distress cause both emotional and physical effects. Nurses have reported feeling angry both toward themselves or others, frustrated, powerless, anxious, helpless, embarrassed, and burnt out (Austin, 2012; Corley, 2002; Green & Jeffers, 2006; McCarthy & Gastmans, 2015; Wilkinson, 1987; Varcoe et al., 2012). As a result, many nurses have experienced somatic symptoms such as heart palpitations, headaches, diarrhea, and insomnia (McCarthy & Gastmans, 2015). The negative experiences of moral distress, coupled with increasing levels of moral residue have resulted in many nurses leaving their positions, or leaving the nursing profession altogether (Austin, 2012; Corley, 2002; Varcoe et al., 2012; Wilkinson, 1987).

Moral distress has also been demonstrated to have an effect at a broader external level in regard to the way organizations function. Burston & Tuckett (2012) discuss how nursing attrition will continue to perpetuate the staffing shortage, leading to increasing levels of moral distress experienced by presently employed nurses. Further, moral distress may have an impact at a systemic level, as the quality of nursing care may decline and utilization of a facility by the public may decrease if these changes are known, ultimately influencing the performance of the organization and cost of service (Burston & Tuckett, 2012).

Nurse Practitioners

Moral distress has been largely studied in the general nursing population, specifically in the role of registered nurses (Pauly et al., 2012). However, research is expanding to encompass multiple healthcare disciplines, including that of physicians, social workers, occupational therapists, physiotherapists, and pharmacists (Astbury, Gallagher, & O'Neill, 2015; Brazil et al., 2010; Hamric, 2010; Penny, Ewing, Hamid, Shutt, & Walter, 2014; Wall et al., 2016). An area in which there is a lack of research in moral distress lies with nurse practitioner practice.

Nurse practitioners are registered nurses with advanced education, preparing them to provide comprehensive healthcare services to the community (College and Association of Registered Nurses of Alberta [CARNA], 2011). In Canada, nurse practitioners are educated at a master's level, with a focus in the nursing model, and a foundation in comprehensive care (CNA, 2016; Wong & Farrally, 2010). The nursing model focuses on a holistic approach that encompasses both health and illness (Wong & Farally, 2010). This model encourages the development of partnerships between clinician and individuals to ensure disease prevention, wellness, and optimal knowledge translation for the purpose of education (Wong & Farrally, 2010). The scope of practice for nurse practitioners is variable, and is often specific to practice

setting and dependent on provincial or territorial legislation. As advanced practice nurses, nurse practitioners have the legal authority and autonomy to "conduct comprehensive health [assessments], to diagnose health/illness conditions, [and to] treat and manage acute and chronic illness" (CARNA, 2011). Although nurse practitioners practice clinically using an evidence-informed approach, they utilize a nursing approach, which places an emphasis on health promotion and holistic care through partnerships with individuals, families, and communities (CNA, 2016). The extensive knowledge and training achieved through education and experience allows nurse practitioners the ability to both work independently and collaboratively (CNA, 2016).

Nurse practitioners play a unique role in the healthcare system. Initially introduced in Canada to address the physician shortage, nurse practitioners have shown to be effective in delivering services comparable to that of a physician (Edwards, Rowan, & Grinspun, 2011). With previous experience as registered nurses, in combination with their advanced education, nurse practitioners possess skills and knowledge that stem from traditional models of medicine and nursing (Gould, Johnstone, & Wasylkiw, 2007). Nurse practitioner care, although focused significantly on clinical symptoms relating to illness, stresses the importance of looking after the "health" of individuals and communities (Gould, et al., 2007). The comprehensiveness of this approach involves moving beyond the singular illness to identify and address the multitude of needs that stem from various physical, psychological, and social aspects (Gould, et al., 2007). This increase in role and higher level of autonomy begs the question as to whether these advanced practice nurses continue to experience the same level of moral distress as their nursing colleagues. In addition, there is more to learn about whether the factors that contribute to nurse practitioners' experiences of moral distress are similar to those of registered nurses.

Continuing Care

Moral distress has been widely researched in a variety of settings including adult, pediatric, and neonatal intensive care units, palliative care, and psychiatric units (Austin, 2012; Austin, Kagan, Rankel, & Bergum 2008; Burston & Tuckett, 2012; Choe, Kang, & Park 2015; Wall et al., 2016). This project aims to assess moral distress specifically in the continuing care environment. Continuing care is defined as a multitude of services that aim to support the health of individuals in a variety of community settings, including their own home, a supportive living facility, or in a long-term care setting. (Alberta Health Services, 2016). The senior population in Canada is projected to increase from 4.2 million in 2005, to 9.8 million by 2036, with 1 in 3 individuals over the age of 65 developing a disability (Government of Canada, 2016). This increase in individual needs will place an increased stress on the currently available continuing care services and resources.

Currently, there are only a few studies that assess moral distress in the continuing care setting (Edwards et al., 2013; Green & Jeffers, 2006; Pijl-Zieber et al., 2008). This literature appraises the ethical issues and dilemmas endured by practitioners, but does not directly link these experiences to the phenomenon of moral distress (Pijl-Zieber et al., 2008). Present literature does however identify contributing factors that are unique to the continuing care setting. These issues include absence of physicians in the continuing care facilities during incidents of needed direction or assistance, lack of nurse-physician collaboration, differences between residents and family wishes, lack of available resources to provide adequate care for residents, and lack of power in practice (Edwards, et al., 2013; Green & Jeffers, 2006; Pijil-Zieber et al., 2008).

Literature Review

An initial integrative review was completed on June 7, 2016 using the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, Medline, Scopus, Academic Search Complete, and PubMed, with the search terms "nurse practitioner*", "long term care home or continuing care setting or nursing home or residential care or assisted living*", and "moral distress". This initial search, once screened, resulted in zero results. The search terms were then adjusted to use only "nurse practitioner*" and "moral distress". The search using these terms was also limited to articles published in academic journals in English, between the years 2005 to 2015. The preliminary search resulted in a total of 50 articles. With duplicates removed, the number of articles was reduced to 16. Screening by title and abstract was completed, eliminating articles that did not specifically relate to both nurse practitioners and moral distress. In using this search criteria, the results totaled three journal articles.

These three articles encompassed two practice environments: emergency departments and primary care (Laabs, 2005; Laabs, 2007; Trautmann, Epstein, Rovnyak, & Snyder, 2015). Each study identified various themes regarding key contributing factors causing moral distress. The methods varied, and included a qualitative study that employed an interpretive description design (Laabs, 2005), a qualitative study that followed a grounded theory methodology (Laabs, 2007), and a quantitative study that used multiple linear regression and Pearson's correlation coefficient (Trautmann et al., 2015). All three of these studies were performed in the United States.

Laabs (2005) conducted a study that identified the ethical issues in which primary care nurse practitioners experienced moral distress. Theses incidences varied among the 71 participants, but did include some common concerns including patient refusal of appropriate treatment, genetic testing, lack of access to healthcare, restrictive insurance and drug

formulations, allocation of resources, rights of minors and parents, abortion, competition between physicians and nurse practitioners, clinical decisions that were made by others, and patients that were unable to pay for services. Additionally, constraints identified were divided among patient constraints and employer constraints. Patient constraints included language and cultural barriers, lack of adequate insurance, and unrealistic demands by patients and families. Employer constraints differed as they related to the limited time allowed to adequately address patient needs, performance pressure as success was based on the volume of patients seen rather than patient complexity or quality of care, lack of physician understanding of nurse practitioners' role and scope of practice, disagreement with physician practice in failing to adequately inform patients of diagnosis and treatment options, and disagreement with other clinicians ordering unnecessary tests. Laabs (2005) also noted that some variance in identifying areas of moral distress were related to the variable definition of the term moral distress, the lack of time to reflect on the ethical aspects of practice, and individual perspectives on whether they had fulfilled their moral responsibility in practice.

Laabs (2007) also conducted a study using grounded theory in which she assessed the degree of distress experienced as it related to moral integrity in the primary care setting. This study analyzed the process in which nurse practitioners come to experience moral distress. This process occurred through 4 phases, beginning with encountering a situation that causes a predicament, the practitioner deciding which course of action they will take to maintain their integrity, finding a way to meet the needs of patients without compromising their moral integrity, and finally evaluating their actions in terms of their ideals surrounding moral integrity (Laabs, 2007). Laabs (2007) placed a heavy focus on phase 4 which identified factors or situations that nurse practitioners viewed as compromising their integrity and the distress that was associated.

Four conditions were examined in which moral distress occurred. These included the nurse practitioners' working environment, the nurse practitioner role and relationship with the patient, nurse practitioner knowledge and experience, and nurse practitioners' perspective and values. Significant external constraints were presented regarding working environment, including time constraints, feeling pressured to attain productivity goals, lack of respect in diversity of practitioner beliefs and chosen practice, and limitations in accessibility of services and resources, especially in marginalized populations.

According to Laabs (2007), nurse practitioners in the primary care setting endured a variety of experiences as a result of ethically-distressing situations. These experiences included feelings of frustration, self-doubt regarding their ability to provide appropriate level of care to patients, regret and disappointment in oneself for not doing what they believed a good nurse practitioner would have done, and outrage toward individuals or entities that they believed caused the moral violation. As a means to resolve the contradiction between what nurse practitioners' expected of themselves versus the reality of transpired events, these individuals utilized strategies to reconcile their actions, including compensating or attempting to counter the distress by lowering expectations of themselves, accepting the limitations experienced, burying their distress in activities such as strenuous exercise, working additional hours, convincing through self-talk that they have done everything they could, and avoiding conflicting situations or distress by either relocating to environments were threats to integrity were minimal or leaving the profession altogether.

A third study completed by Trautmann et al., (2015) analyzed moral distress in nurse practitioners in the emergency department using a quantitative assessment tool. Two main issues that were found to be associated with nurse practitioners' experiences of moral distress were

witnessing poor patient care that resulted from poor staff communication, and working with less competent nurses and colleagues. Trautmann et al., (2015) identified that significant psychological stress from practicing emergency medicine and the autonomy in making independent clinical decisions related to high levels of moral distress. This also correlated to many nurse practitioners either considering or leaving their current practice. Because of this high correlation, Trautmann et al., (2015) suggested the need to address situations that are likely to result in moral distress in order to improve job satisfaction and retention.

It is apparent that the themes encountered in the two practice settings are variable, with minimal overlap. In the primary care setting, it appeared that the experience of moral distress resulted from factors that were at both personal and environmental level. These issues spanned availability of resources, attainability of services for patients, and interactions among employer and colleagues (Laabs, 2005; Laabs 2007). In the emergency department setting, however, moral distress appeared to be more specifically related to poor quality of patient care and stress associated with emergency care itself. Further research is needed to assess whether the experience of moral distress is specifically related to the practice setting, or if there are common encounters throughout a variety of practice environments.

Methods

To choose an appropriate method of inquiry, Creswell (2014) stresses the importance of acknowledging the researcher's worldview, or in other words, how the researcher views the topic at hand and what the pertinent factors are that require addressing. As this study is based on the experience of moral distress by nurse practitioners and ultimately focuses on the potential impact and consequences of the phenomenon on both a personal and professional level, constructivist and interpretive methods were employed to explore the following research questions. Social

constructivism is a worldview in which "individuals seek understanding of the world in which they live and work" (Creswell, 2013, p. 24). The goal of social constructivism is to gain meaning not only from the individual participants, but in their experienced interactions with other individuals and environment, all while including the evolution of social norms (Creswell, 2013).

As an approach to research design, I utilized the method of interpretive description (ID). This approach aligns with "interpretive naturalistic orientations…[while acknowledging] the constructed and contextual nature of human experience that at the same time allows for shared realities" (Thorne, Kirkham, & O'Flynn-Magee, 2004, p. 3). ID recognizes the difficulty in qualitative research in that often times, a discrete research design does not allow for a comprehensive method of data collection and analysis as the anticipated method may not be align with a singular methodology (Hunt, 2009). Rather, ID was developed as a non-categorical research design that draws from various methods including grounded theory, interpretive phenomenology, and ethnography (Hunt, 2009: Thorne, Kirkham, & MacDonald-Emes, 1997). ID is promoted as an ideal method for health sciences, as it emphasizes the development of knowledge to inform clinical practice by means of identifying themes and patterns both amongst and between participants (Hunt, 2009; Thorne 2016). Thorne (1997) distinguishes ID from other qualitative research methodologies as it upholds the three tenets put forth by Lincoln and Guba (1985). These include ensuring that "there is no pre-selection of variables to study, no manipulation of variables, and no a priori commitment to any one theoretical view of a target phenomenon" (Lincoln & Guba, 1985, p. 337). Further, Thorne et al., (2004) emphasizes that ID differs from traditional qualitative methods as the intent of researchers is to "[explore] meanings and explanations that may yield application implications" in the clinical setting (p. 6). ID is an ideal method for this research study as it is focused on understanding the lived experience of

moral distress by nurse practitioners in the continuing care setting, and utilizing these findings to assist in directing future clinical changes.

For this research study, I employed ID to guide my development of the research questions, data collection and analysis, and contextualization of the results. Gaining a better understanding of the experience of nurse practitioners and moral distress in the continuing care setting will assist in identifying contributing factors that influence the experience of this phenomenon. Results obtained may assist in future research for developing appropriate methods of addressing moral distress in this specific population.

Research Question

The overarching research question for this study is:

What are the experiences of moral distress of nurse practitioners in the continuing care setting?

Specific sub-questions include:

1. What factors contribute to continuing care nurse practitioners' experiences of moral distress?
2. What issues need to be addressed to lessen the experiences of moral distress for nurse practitioners in continuing care?

Recruitment and Sample

Inclusion criteria. Approval was obtained by the University of Alberta Research Ethics Board (REB) 1, on January 6, 2017. During recruitment, I sought out English speaking nurse practitioners that held current registration in Alberta, who were actively employed in the continuing care setting. These practitioners must have been practicing in this setting for a period of more than 6 months and must have experienced a situation that was morally distressing. I utilized purposive sampling to obtain an ideal sample for the study. Thorne (2016) identified

purposive sampling as an appropriate method of gaining a research sample, as it allows for a broad variety of experiences and well-balanced results.

For the initial recruitment, I sent an information package to individuals that worked within the desired practice settings, whose contact information was publicly available. Additionally, I was invited to present my proposed research study to the continuing care nurse practitioner group during their monthly meeting on February 9, 2017. This presentation included an introduction of the research topic and purpose. Recruitment packages were brought to this meeting and distributed among the nurse practitioners following the presentation. Recruitment packages included invitations to the study (Appendix A) as well as information sheets/consent forms (Appendix B) for both themselves and for them to pass on to other potential participants. Attached to the recruitment letter was an interest form. Potential participants then completed this form and either mailed it to the research team or contacted me directly at the provided phone or e-mail address. Following initial contact, we arranged a mutually agreed upon a place and time to meet to complete the initial face to face interview.

As previously mentioned, the setting of interest for this study was continuing care. Participants were recruited from the three different community settings within continuing care. The first program was comprised of paramedics and nurse practitioners, and was developed to decrease transfers to acute care facilities while providing necessary care in the patient's home. In many facilities, the most responsible practitioner (e.g. physician or nurse practitioner) is not always present. This innovative program supports the work of unique practitioners to do assessments and develop treatment plans with the provision of some interventions within continuing care settings, without the need to transport to hospital. This plan to treat in place assists in reducing the overall stress on the healthcare system, while allowing patients to feel

comfortable in their own environment. The second program involves nurse practitioners that provide in-home assessment and treatment on a referral basis. These patients often have multiple complex comorbidities and require varying levels of intervention. Additionally, these patients often are unable to leave their home for a multitude of reasons and require the nurse practitioners to travel to their private homes to provide interventions as required. These patient visits are often episodic but may require the ongoing treatment of nurse practitioners. The last program consists of a group of nurse practitioners that provide care for individuals who live in facilities of varying levels of care. These individuals have complex and diverse health issues and require a higher level of care with their activities of daily living. Nurse practitioners in this team function on a consultative, episodic basis in which they assess and treat patients living in a care facility.

Sample size. Research designs that follow an ID approach may have samples of any size (Thorne, 2016). Thorne (2016) states that the best way to justify a sample size is by generating rationales that are consistent with the research question or, in other words, deciding on what an appropriate number would be to give the study merit (Thorne, 2016). Thorne (2016) also cautions using the term "saturation" as it tends to describe a comprehensive end to collecting data, assuming that all dimensions have been documented and discovered and there are no new understandings to be gained. With an ID research design, Thorne (2016) believes that it is impossible to fully learn all dimensions of themes and that understandings may change. The sample for this study included six participants. The interviews conducted were rich in quality and provided substantive information and perspective to answer the research questions.

Data Collection

Data collection occurred during audio recorded face to face interviews. These interviews took place following initial contact, at a mutually agreed upon place and time. Thorne (2016)

stresses the importance of interviewing in a comfortable setting for the participant as it allows them to feel less awkward and uninhibited with their responses. The location of the interviews was variable and included both workplace offices and private meeting rooms at the University of Alberta. These environments were utilized to provide privacy and comfort, to ensure participants were forthcoming with information, and to ensure for optimal knowledge translation.

Along with the recorded interviews, I also took field notes to record emotions or thoughts during the interview, and to capture any information that was not obtained during the recording or any afterthoughts of the participants. These notes assisted me in revisiting sections of the interview that may have spurred new ideas or meaning of the phenomenon at a later time. The focus of the time during these interviews was on the participant while they were speaking their experience, as that is the main goal of the study.

Individual experiences are personal. Often times, interviews regarding an individual's experiences may lead to difficult thoughts and sensitive topics. As such, I stressed during these interviews that the information shared was fully confidential and would not be disclosed to anyone outside of the research team. In addition, I also informed the participants that personally identifiable information would not be used, and the information collected would be reported in aggregate form. Any information that was subject to specificity would be disclosed using participant codes, rather than names. As a researcher, I am aware that disclosing information during these interviews could cause the participants distress. Because of this, I acknowledged that these individuals were reflecting on difficult situations, that time may be required to process these events fully, and offered breaks during the interviews as needed. In addition, external resources for counselling are an essential resource for participants, and were offered both during obtaining consent, as well as at the end of each interview.

Data Analysis

Following the interviews, the audio recorded data were transcribed by a third-party transcriptionist. To protect the participants, a confidentiality agreement was signed by the transcriptionist, and all personally identifiable information was removed.

ID data analysis is characterized by continued revisiting of data (Thorne, 2016). Superficial coding allows for initial themes to be formed, with the hope that relationships among the themes will begin to develop (Thorne, 2016). Transcripts were reviewed following the interviews early on as timely exposure assisted in the development of new insights and questions which were incorporated in future interviews. During further immersion in the data, memoing was used as a means to code or sort the information in a manner consistent with my evolving analytical process. Grouping information in a sensical way permits relationships and patterns to be identified, allowing for the development of theoretical concepts that may lay the foundation for future change (Thorne, 2016).

Validity and Rigor

Qualitative validity is enhanced when "the researcher checks the accuracy of their findings by employing a certain procedure" (Creswell, 2014, p.201). This ensures that the data collected is accurate from multiple standpoints: the interviewer, the participants, the audience (Creswell, 2014). In the ID approach, validity and rigor are maintained through various means. To ensure validity and rigor, the transcripts were read against the audio recordings to ensure that they were verbatim copies. Following examination of the data and provision of preliminary findings, Thorne (2016) discusses "member-checking," the process in which participants have the opportunity to review the research results and discuss the overall consistency with their own experiences (p. 112). This allows opportunity for additional interviews if necessary, in which

concepts may be clarified or further explored (Hunt, 2009; Thorne, 2016). Member checking was completed following analysis of the data. The results were provided to the participants by e-mail, and feedback was obtained to confirm consensus of the findings. Final results were reviewed and related back to the initial research question, ensuring that the information collected reflects the initial intent of the study.

Significance of the Research and Relevance to Practice

The phenomenon of moral distress is gaining the attention of many researchers. There is a large body of evidence demonstrating the negative effects of moral distress on healthcare professionals across the spectrum. Unfortunately, there is a severe lack of research relating to nurse practitioners, specifically in the field of continuing care. Canada's population is aging, and as such, the stress on our healthcare system will be increasing. Nurse practitioners working in the continuing care setting may contribute significantly to alleviating this strain by enacting more practices of "treat in place". It is imperative that we gain a better understanding of the experiences of moral distress by these professionals so issues may be addressed, and that the effects of negative emotions and burnout may not plague this body of practitioners to the extent of attrition.

Chapter 2

Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

This study explores the experiences of moral distress in nurse practitioners within the continuing care setting. The Canadian population is continuing to age, and as such, the strain on the healthcare system is increasing (Canadian Medical Association, 2016). Nurse practitioners may play a fundamental role in alleviating some of this stress in their practice within the continuing care setting. Unfortunately, nurse practitioners are only now beginning to gain momentum in Canada, especially in the province of Alberta. As such, there is potential for these individuals to encounter situations related to a variety of contributing factors that may cause them to experience moral distress.

There is a notable lack of literature on moral distress in the nurse practitioner population with current research focusing largely on the general nursing population, specifically on registered nurses in a variety of acute care settings (Austin, 2012; Burston & Tuckett, 2012; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). The aim of this study was to gain a better understanding of the experience of moral distress in the nurse practitioner population in the continuing care setting, as a means to understand the similarities and variances of experiences, as well as the contributing factors from that of the general nursing population. Nurse practitioners have the ability to influence individual and population health by increasing access to care, educating patients, and providing high quality care, specifically in chronic disease management (Canadian Nurses Association, 2016). By gaining a better understanding of their experience, we can gain insight into the factors that influence these experiences, potentially identifying solutions to alleviate moral distress. It is imperative that we gain this insight to reduce incidence of moral

distress that this group of practitioners may be exposed to, and ideally prevent them succumbing to the currently known negative outcomes.

Background

The phenomenon of moral distress has been of increasing interest in the research literature over the past 30 years. Jameton (1984) initially defined moral distress as when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Moral distress can occur when initially exposed to a distressing situation, or can be more reactive, causing moral residue, when an individual is unable to act in such a situation (Jameton, 1993; Pauly, Varcoe, & Storch, 2012).

Moral distress has been studied across the spectrum of healthcare professionals. Until recently, much of the research performed was focused on registered nurses and their experiences within sensitive practice settings, which included intensive care units, mental health, and palliative care (Austin, 2012; Burston & Tuckett, 2012; Varcoe, Pauly, Webster, & Storch, 2012; Wall, Austin, & Garros, 2016). As a result of their experiences of moral distress, nurses have reported feeling angry, frustrated, powerless, anxious, helpless, embarrassed, and burnt out (Austin, 2012; Corley, 2002; Green & Jeffers, 2006; McCarthy & Gastmans, 2015; Wilkinson, 1987; Varcoe et al., 2012). Further, many nurses have progressed to experiencing somatic symptoms such as heart palpitations, headaches, diarrhea, and insomnia (McCarthy & Gastmans, 2015). The negative experiences of moral distress, coupled with increasing levels of moral residue have resulted in many nurses leaving their positions or leaving the nursing profession altogether (Austin, 2012; Corley, 2002; Varcoe et al., 2012; Wilkinson, 1987).

Nurse practitioners are registered nurses with advanced education, preparing them to provide comprehensive healthcare services to the community (College and Association of

Registered Nurses of Alberta [CARNA], 2011). In Canada, nurse practitioners are educated at a master's level, with a focus in the nursing model, and a foundation in comprehensive health (Canadian Nurses Association [CNA], 2016; Wong & Farrally, 2010). The nursing model encompasses a comprehensive focus that includes both health and illness (Wong & Farally, 2010). This model encourages the development of partnerships between clinician and individuals to ensure disease prevention, wellness, and optimal knowledge translation for the purpose of health education (Wong & Farrally, 2010). As advanced practice nurses, nurse practitioners have the legal authority and autonomy to "conduct comprehensive health [assessments], to diagnose health/illness conditions, [and to] treat and manage acute and chronic illness" (CARNA, 2011). Nurse practitioners are also capable of ordering and interpreting diagnostic tests, performing certain procedures, and prescribing medications and therapeutic interventions (CNA, 2016). Although nurse practitioners practice clinically using evidence-informed methods, they utilize a nursing approach, which places an emphasis on addressing patient needs and ensuring patient satisfaction through health promotion and holistic care (CNA, 2016; Stahlke Wall & Rawson, 2017). The extensive knowledge and training achieved through education and experience allows nurse practitioners the ability to work both independently and collaboratively (CNA, 2016).

Nurse practitioners may be ideal clinicians in the setting of continuing care. Continuing care is defined as a multitude of services that aim to support the health and wellbeing of individuals in a variety of community settings, including their own home, supportive living facilities, or in the long-term care setting (Alberta Health Services, 2016). In Canada, the population of individuals aged 65 and older is projected to increase from 4.2 million in 2005, to 9.8 million by 2036, with 1 in 3 individuals developing a disability (Government of Canada, 2016). This increase in individual needs will place an increased stress on the currently available

continuing care services and resources. Utilization of nurse practitioners in the continuing care setting can assist in addressing both the acute and chronic needs of this population, as a means to assist in alleviating the overall strain on the healthcare system.

Purpose

The purpose of this study was to gain an understanding of nurse practitioners' experience of moral distress in the continuing care setting by addressing the following research questions: What are the experiences of moral distress of nurse practitioners in the continuing care setting? Specific sub-questions include: What factors contribute to continuing care nurse practitioners' experiences of moral distress? What issues need to be addressed to lessen the experiences of moral distress for nurse practitioners in continuing care?

Methodology

Study Design

The design utilized for this qualitative study was interpretive description. This method is ideal as it focuses on the generation of knowledge that is relevant to health disciplines (Thorne, 2016). Interpretive description aims to identify patterns and meaning in an experienced phenomenon that can assist in generating knowledge that may be directly utilized to impact healthcare practice (Thorne, 2016). Interpretive description stresses the importance of understanding the lived experience of individuals to best represent the phenomenon. In this study, the experience of nurse practitioners will be learned to better understand the phenomenon of moral distress as it exists in the continuing care setting.

Sample

The sample for this study was obtained through purposive sampling. Participants were recruited from various continuing care programs in a large urban setting in Western Canada.

Inclusion criteria for this study included nurse practitioners that (1) had been practicing for a minimum of 1 year; (2) had been practicing in continuing care for a minimum of 6 months; (3) spoke English; (4) had had an experience of moral distress.

Ethical Considerations

Ethics approval was granted by the University of Alberta Research Ethics Board prior to commencement of this study. To maintain confidentiality of the participants, identification numbers have been assigned and will be used throughout the paper to preserve anonymity.

Data Collection

Data collection occurred during audio recorded face to face interviews. These interviews took place following initial contact, at a mutually agreed upon place and time. Interviews averaged an hour in duration and followed a semi-structured interview guide (Appendix D). The purpose of these interviews was to gain insight into nurse practitioners' experiences of moral distress, as well as acknowledge the factors that contributed to these experiences. The interview guide included both broad, open-ended questions such as, "Tell me about your experiences of moral distress?" and more specific questions including, "What impact did these experiences have on your practice?"

Data Analysis

Interpretive description data analysis is characterized by continued revisiting of data (Thorne, 2016). Superficial coding allowed for initial themes to be categorized and labelled; relationships among the themes were then identified (Thorne, 2016). Transcripts were reviewed following the interviews early on as timely exposure assisted in the development of new insights and questions, which were incorporated in future interviews. During further immersion in the data, memoing was used to code or sort the information in a manner consistent with my evolving

analytical process. Transcribed interviews were imported into QSR International's NVivo version 11 software for thematic analysis. Grouping information in a thematic way permitted identification of relationships and patterns, which allowed for the development of theoretical concepts that may potentially lay the foundation for future change (Thorne, 2016).

Validity and Rigor

Interviews were transcribed through the aid of a third-party transcriptionist, who signed a confidentiality agreement. To ensure credibility of the data, the transcripts were read against the interview recordings to ensure a verbatim copy. The primary investigator conducted the initial review of the transcripts, in addition to the initial coding of the data. Coding was also completed by an additional member of the research team, with themes compared to ensure consensus of the interpretations. Additionally, member-checking was completed by providing the results back to the participants to ensure that the interpretation and presentation of the data aligned with their original intent.

Results

All participants (n=6) were female nurse practitioners that were practicing in the continuing care setting during the time of recruitment. Their previous experience as registered nurses varied among practice settings and included home care, long-term care, emergency, rural, medicine, surgery, palliative care, and high-risk obstetrics. The mean age of the participants was 44, and the average length of nurse practitioner practice was 6.4 years with the range extending from 1.25 years to 15 years. Nurse practitioners in this study attended to patients living in a variety of continuing care settings. These settings included both facilities and private homes. They described the patients that they provided care for as often very complex, with needs that

spanned the medical, psychological, and social spectrum. One participant described an example of this complexity in a continuing care patient who:

> "[has] chronic malnutrition…has a history of celiac and IBS…[and is] a heavy smoker…[She] lives alone [with] no support, [and] is in a relationship with a significant amount of domestic violence…She [also] suffers from a chronic history of depression [and] previous alcoholism." (P01).

In addition to complex patients, nurse practitioners in this study reported independent and collaborative work with a variety of other professionals, including physicians, nurses, and management teams.

All participants shared their experiences of moral distress in their careers as nurse practitioners in the continuing care setting. However, many of the participants were unaware that they were experiencing this phenomenon, and required significant probing during the interviews to identify these experiences. Probing was not used to guide individuals, rather the use of open-ended questions assisted them to reflect and identify specific experiences that they deemed as morally distressing. Five main themes pertaining to the various tensions that were evident in their experiences of moral distress were identified in the data analysis. The five themes are: patients, perceptions, physicians, palliation, and policies. Each of these themes will be described in detail in this section of the paper.

Figure 1

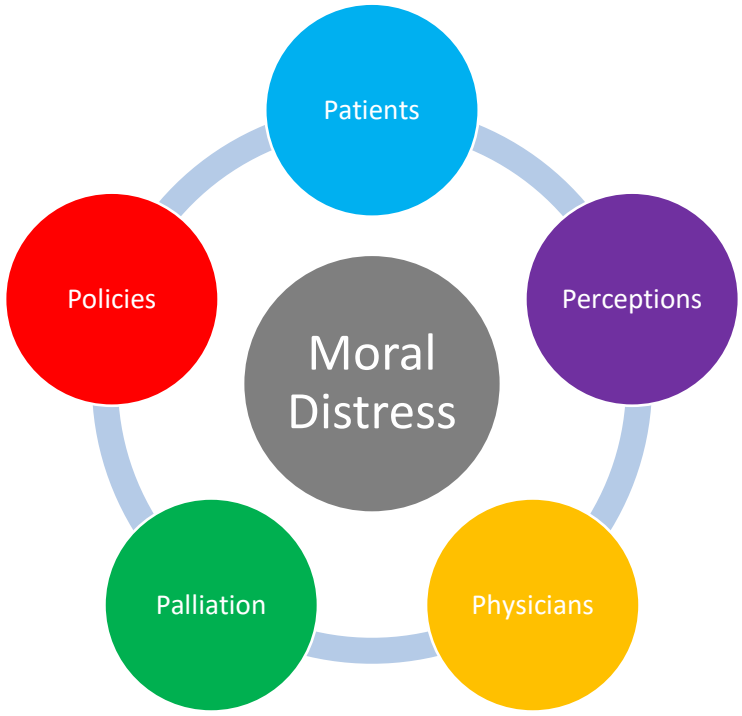

Table 1

Theme	**Conceptual Definition**
Patients	Tensions that arises from the nurse practitioner's desire to provide "good care" for their patients and constraints in providing this care due to the complexity of patient needs, accessibility to patient care resources.
Perceptions	Tensions that arise between the nurse practitioner and family members, as well as managers due to individual perceptions about the nurse practitioner role and scope of practice.
Physicians	Tensions that arise between nurse practitioners and physicians due to the presence of a "power struggle" between physicians and nurse practitioners as a result of the lack of respect for the nurse practitioner role.
Palliation	Tensions that arise for the nurse practitioner from the struggles to meet the multiple demands of the various individuals involved in palliative care and the lack of palliative care resources available.
Policies	Tensions that arise for the nurse practitioner due to a misalignment between organizational expectations and professional responsibilities of their role and the realities of practice, particularly time demands.

Patients

All participants spoke about their experiences of moral distress in relation to the pull between wanting to "do good" care for their patients and their ability to do so. Participants spoke about a variety of factors that inhibited their ability to do what they knew to be the "best care" for patients, including complexity of patient needs, restrictions in accessing diagnostic resources in a community care setting, supplementary duties that took time away from patient care, and the hypervigilance required to ensure at least "safe patient care".

All six participants discussed patient complexity as a contributing factor to their experience of moral distress. They described patients as having multiple comorbid medical issues, in addition to psychological and social struggles. For example, one participant described a very complex situation involving a patient with a musculoskeletal injury that was compounded by various complications and unrelated co-morbidities such as a hematoma, skin disorders, infection, and swelling, pointing out that "[we] do all the interventions for people who can't access it elsewhere" (P01). The patients that the participants interacted with spanned the spectrum of stable to unstable, with the possibility always looming that their health status could change within minutes.

Participants discussed their ethical concern for providing evidence-based practice in an environment where they faced restrictions in accessing diagnostic resources. One participant talked about her limited ability to access urgent blood tests for a bedbound patient with limited family support, saying "You want stat blood work, good luck with that. Like it's not going to happen…No [one is going to] come from [the lab] until Monday next week, and you're on Tuesday" (P05). This participant described her distress in terms of feeling like "you're a slave to a system that's not designed for having home resources" (P05). Another participant described

having "to work within those constraints" (P02) to provide care within very difficult situations. She described a complex patient care situation involving a bedridden bariatric patient requiring a chest x-ray, who could not leave his house nor afford a mobile x-ray. She reflected that "ideally, clinically I would want a whole bunch of investigations that could help guide me on the right path for management" (P02), although, in reality she did not have access to the necessary diagnostic resources.

Participants also described that, in their roles, they were often both clinician and support staff. In addition to their clinical responsibilities, participants talked about being responsible for ensuring that all clerical work was completed and that all parties that participated in patient care were made aware of new interventions and changes to the care plan. This work included ensuring that the most responsible practitioner, normally a physician, was aware of the changes, as well as pharmacies and case managers. As one NP participant explained,

> "Because the facilities are run independently, we need to ensure that the front-line staff delivering the care have the orders. We also need to…ensure that the [organizational] staff have the orders. We also need to ensure that any other physician who's involved or a primary care provider is aware. [They] also use community pharmacies…[There] are quite a few places that our documentation needs to go" (P02).

For these NPs, clerical responsibilities contributed to significant distress. They believed that taking time away from patient care to attend to clerical duties was an unethical constraint on their time and prevented them from providing the "best/safe care" for their patients, to the point that "[You] can sometimes feel like you're juggling about 10 balls in the air. Because you're dealing with so many people…[and] we're all over the zone. I'm so afraid of dropping a ball…to someone's detriment" (P04).

Perceptions

Many participants spoke of the tensions they experienced due to the individual perceptions of family members and managers about the nurse practitioner role and scope of practice. They discussed their turmoil during encounters with these individuals when their expectations did not align with the participants' intended plan of care, causing them to make ethical decisions regarding the correct course of action.

Participants discussed how family dynamics and perceptions of the nurse practitioner role have caused them to experience moral distress. Many encountered situations in which the expectation of the family members differed from that of the participant, causing them to question their own competency, and feeling torn in making ethical decisions regarding care. One participant described a situation in which the family member had questioned her clinical competency based on the family member's own anecdotal experience, causing her to feel "[stressed] that [you] may have treated [the patient] incorrectly" (P04). Another participant described a situation when family members expected care in the community to be the same as those in hospital. She explained that the family's expectation of her were significantly different than the services that she could offer. She reflected on the situation, pointing out "What can you do? Your heart hurts for them, because you know they're scared" (P05). Family perceptions caused the participant to experience moral distress, as she knew the limitations of her role in the community, but she felt compelled to do more to meet the needs of the family, a reality that could not be achieved within the constraints of her role.

Many participants also discussed the individual perceptions of managers regarding the nurse practitioner role and the tensions that arose when their expectations differed from that of the participant. Participants explained how the management teams that they reported to did not

have an advanced practice nurse, but rather were comprised of various other professionals, including social workers, occupational therapists, and nurses. This lack of advanced nursing practice experience contributed to misunderstanding of the comprehensiveness of the care that was provided by participants. Participants verbalized their desire to engage with management regarding ethical situations and concerns they encountered in their daily work. However, previous futile attempts, in conjunction with a perceived lack of experience of patient care situations, caused participants to fear that their decisions would be perceived as unnecessary or unimportant, potentially exposing them to negative consequences. One participant stated, "We're trained to vocalize our concerns…and ask the hard questions and debate, but we're reprimanded for that…by our managers" (P04). Further, participants spoke of how management's perception of their role had led to inappropriate utilization of nurse practitioners, including "inappropriate referrals, or referrals for patients that [were] already being looked after by a physician" (P03). Participants experienced moral distress when having to decide whether they fulfil the obligations set out by their managers, or continue in their own practice to meet the needs of the patient. In response to these situations, one participant stated that they were often "flying under the radar" (P03) to ensure that they meet the needs of their patients while avoiding negative consequences.

Physicians

All participants spoke about their experiences of moral distress with wanting to be part of a collaborative team for the good of the patient, but tensions arose due to an apparent power struggle with physicians. Participants discussed a variety of situations where physicians appeared to manipulate patient circumstances to remain superior to the nurse practitioner. These situations included physicians ignoring communication from participants about mutual patients, physicians refusing to sign death certificates when not immediately involved in the patient's care, and a lack

of respect for the nurse practitioner as demonstrated by inappropriate requests for patient services that did not require a nurse practitioner level of skill. All of these situations appeared to have caused the participants moral distress as these situations not only cause tension in an already "fragile relationship" (P05), but also limited their ability to provide "good" patient care.

Many participants discussed communication as a factor that contributed to their experience of moral distress. They spoke of how some physicians "[felt] a sense of ownership over their patient" (P01) and that they exhibit their power over nurse practitioners by choosing to forego communication. One participant discussed her frustrations and anger when nurse practitioners were "constantly having to be the one that is closing the gap" (P05) between themselves and physicians. She expressed her distress in that "[physicians] might take over and you might not know anything that they're doing…[and] you feel like you go to a great extent to have this communication relationship, and it's not reciprocated" (P05).

Participants also discussed restrictions in their practice and how the need to collaborate with physicians to ensure comprehensiveness of patient care was often a struggle. One participant spoke specifically about a situation in which "the family GP hadn't been engaged for a year and would not sign the death certificate" (P03). Additionally, another participant discussed her need to phone the physician prior to her interventions in patient care as a "courtesy" (P06), in the event that the patient passes away, as she too is unable to sign the death certificate. These situations caused participants to experience moral distress as they observed a seeming lack of patient and family centeredness, a focus on physician-centric practices, and their desire to exert power over the nurse practitioner through obstructing completion of patient care.

Participants also discussed the distress they experienced when tensions arose regarding physicians' lack of respect for the nurse practitioner role. Participants spoke of how physicians

consulted and utilized nurse practitioners inappropriately and in a manner, that appeared to demean their role. One participant spoke of an interaction she experienced, when a physician requested that she provide an intravenous fluid bolus for a patient, which she perceived as belittling their scope of practice (P06). She discussed how "[a physician] wouldn't ask…another physician to do a bolus", and similarly should respect the role of nurse practitioners in the same manner. Participants spoke of their ethical struggle in encountering these interactions with physicians and the overall effect that it has on the forming of collegial relationships and ultimately, the impact on patient care.

Palliation

All participants spoke of the moral distress that they experienced during the provision of palliative care services to complex patient populations due to the tensions that arose in their inability to meet the needs of various key stakeholders. They spoke about their role in assisting patients during their transition that ultimately allowed them to succumb to their comorbidities, and the ethical stress they experienced in knowing that the care they provide may be restricted due to their attempts to meet the needs of others that are present. Participants identified two specific factors that contributed to these situations of moral distress: their inability to meet the needs of all key stakeholders during dire situations, and the lack of provision of care by other healthcare professionals that have not accepted the idea of palliative care. Participants acknowledged that during these situations, they felt torn to make ethical decisions that appeased all individuals involved.

Situations of imminent death were seen as very morally distressing for participants. Participants spoke about the needs of multiple stakeholders in the patient's care. These stakeholders included family members, physicians, and other healthcare professionals.

Participants discussed feeling torn about making the right decision when the varying needs of stakeholders countered one another. An example was described where,

> "[The patient] has a known reason for why her life is going to be ending. She's a [full code] at the time of the goals of care…She is…actively dying at the [same] time the physician is saying,… 'If the sister is not the legal guardian and even though she's listed, I want her to go to hospital.' Before [the patient] went unconscious, [she] had verbalized not wanting to go to hospital…So the moral distress of taking somebody's word, when they have dementia, because you know they're not cognitively well, and the exact same moral distress [in] having a sister that's grieving, who wants her to stay there, and you have a physician saying she can't. And…even just the moral distress of staff members looking at you for guidance, and I'm petrified." (P06).

Participants also discussed the lack of acceptance of other healthcare professionals to participate in palliative care in community settings. Some community living facility staff continue to hold the expectation that patients should go to hospital to die. One participant described how this lack of acceptance by facility staff caused her to "feel like I don't trust them when walking away…because I know that something is probably…not [going to] go well" (P05). Facility staff's unwillingness to participate in palliative care has also caused participants to feel torn in the way that they manage patient care, as they described the staff as "[seeing] you as a person who's going to come and write a bunch of orders that they don't want to do" (P05). These situations resulted in participants having to make ethical decisions regarding the type of interventions that they ordered to appease the staff, potentially at the cost of good patient care.

Policies

Many participants spoke of the tensions they experienced when organizational policy conflicted with the regulations set forth by their professional body. Participants discussed their feelings of turmoil when deciding which policies to uphold, as they could interfere in the degree of patient care that they could provide. Further, participants also discussed their ethical indecision in support for their professional regulatory body as the agenda of the association appeared to differ from that of participant expectations.

Participants discussed a feeling of disconnection between professional regulations and organizational policy and how these often countered one another. Participants discussed how they had a professional obligation to perform in a certain way, but that the organization "puts different demands" on them (P02). An example of this was offered by a participant when she received diagnostic test results outside of her normal work hours, but knew that it was her "legal responsibility…[to respond] in a timely manner" (P01), as mandated by her professional association, especially since failure to do so could negatively impact the health of a patient. Further, she discussed that the concept of overtime was not supported by the organization, but was deemed a necessity to meet the obligations of the professional association. The misalignment between organizational and professional body contributed to participant experiences of moral distress as they were torn between which policies versus regulations to uphold in their practice.

Many of the participants also discussed the apprehension and the pull they experienced regarding loyalty to their professional association, as the expectations of participants and the agenda set forth by the professional association differ substantially. They discussed how, although they were expected to uphold regulatory policy, they struggled in their decision to do so

at times, as they felt a lack of support as clinicians from the professional body. One participant discussed this conflict of interest in how their professional association was responsible for "[representing] and [protecting] the public" in addition to nurse practitioners and how "you can't have one body doing both" (P06). Further, the participant discussed the lack of social support by the professional body for the many difficult situations that nurse practitioners encounter on a regular basis (P06). She discussed her desire to engage with other nurse practitioners for validation and support through unauthorized social media, but feared the negative consequences she was faced with in doing so (P06). Participants struggled in maintaining loyalty to their professional association as they felt unsupported, and feared any potential contact.

Addressing Moral Distress

In addition to talking about the factors that contributed to moral distress, participants also shared strategies and personal methods to address moral distress. All participants discussed setting boundaries for themselves regarding their practice as a means of decreasing the effects of moral distress. These boundaries were meant to address the demands on their time and were set up as a mechanism to separate themselves from their professional work/self. Boundary setting was accomplished through the utilization of other available services for patients when they could predict their prognostic trajectories. Participants also engaged in self-care activities such as exercise and group activities and social activities with peers and family members that were not part of their normal work life.

Another method that all participants utilized to address their moral distress included discussions with their peers regarding specific patient situations. Participants described "[wanting to] know [that] you did the best you possibly could" (P03), and that this engagement allowed participants to gain validation for their actions. They referred to their team as their

"lifeline" (P04) and explained that the support they received was substantial in gaining knowledge and acknowledging that they had done the right thing.

All of the participants spoke of strategies that assisted in alleviating some of their encounters of moral distress. A common strategy involved better communication with other key players in the healthcare system regarding their role and scope of practice. They argued that a better understanding of their role in patient care could assist in ensuring that they were utilized appropriately and respected by those involved. One participant spoke at length about how "moral distress comes from both sides of the conversation not being known to everyone" (P06) and that increasing communication should extend to educating one another to ensure the best outcome for the patient.

Lastly, participants discussed the importance of their organization identifying the need to have an advanced practice nurse in the managerial role. They spoke about the importance of having someone who has experienced the situations they had encountered, as they could assist in navigating barriers with the participants. One participant had discussed the experience of having a previous manager who was an advanced practice nurse and explained how she really "pushed our practice and expanded our practice" (P04). She further spoke of how having a manager that understood the role and scope of practice of nurse practitioners was an asset in providing role clarity and ensuring proper utilization of these individuals in the healthcare system.

Discussion

This study has provided an important understanding of the experience of moral distress of nurse practitioners in the continuing care setting. The literature on moral distress is growing, with the majority of research focused on the general nursing population. This study contributes uniquely to what is already known about the experience of moral distress, providing a new view

from the perspective of nurse practitioners. Analysis of the data revealed five themes that were found to contribute to participants' experiences of moral distress. The themes were patients, perceptions, physicians, palliation, and policies.

The initial theme of "patients" was described by participants to be specific constraints that the nurse practitioner experienced in attempting to provide "good" care. Participants spoke of the difficulty they encountered when providing care to complex patients, especially when they were faced with constraints that limited the availability of resources, and supplementary duties that restricted their time with patients and families. This finding is similar to two previous studies completed by Laabs (2005; 2007) in which nurse practitioners providing care in primary care reported constraints in their attempts to provide "good" care. As an American study, these constraints were due to insurance coverage and their need to tailor treatment based on services covered (Laabs, 2005). Registered nurses experienced similar constraints related to workload, more specifically inadequate staffing levels and units working on an over-capacity basis, causing nurses to provide decreased quality of care (Varcoe, et al., 2012).

"Perceptions" was described by participants as individual perceptions of family members and managers of the nurse practitioner role and scope of practice. Participants spoke about the tensions experienced when their expectations for care and the expectations of family members did not align, especially during difficult situations. Laabs (2005) discussed a similar finding in primary care where there were often discrepancies regarding code status and honoring patient wishes for patients during times of imminent change. Perceptions of managers regarding the nurse practitioner role and scope of practice was also an area in which many participants expressed their concern. They talked about the lack of support from these individuals, often due to a lack of understanding regarding their role and the comprehensiveness of situations and

patients encountered. Participants felt they were unable to discuss difficult situations with their mangers, as previous attempts to do so resulted in futility, or the perceived inappropriateness of interventions by their managers could extend to negative consequences. Similarly, registered nurses have also experienced the same issue with management on medical units (Humphries & Wood, 2016; Wall, Austin, & Garros, 2016). Registered nurses reported feeling unsupported during difficult situations in which they experience moral distress, and have been silenced when speaking out about their concerns as these issues were transformed into a "disciplinary matter" (Wall & Austin, 2008).

The theme of "physicians" was discussed by all participants. The findings revealed that a significant power struggle was present between nurse practitioners and physicians, as demonstrated by their lack of respect for the nurse practitioner role and scope of practice. Unlike registered nurses, nurse practitioners have the ability to influence medical decisions that are made regarding patient care (Humphries & Wood, 2016). This change in scope of practice appeared to reject the previously present "hierarchal nature of the nurse/physician relationship" (Burston & Tuckett, 2012, p. 315). Nurse practitioners have, in some way, leveled this hierarchy. However, this change has caused physicians to feel threatened and act out by manipulating patient circumstances (Stahlke Wall & Rawson, 2017).

The theme "palliation" was discussed by participants as the distress experienced with patient care when death was imminent, and the tensions that arise when the demands of various stakeholders, including family members, physicians, and other facility staff, do not align. As palliation continues to transition to the community, incidence of patients dying outside of acute care facilities will increase (Brazil, Kassalainen, Ploeg & Marshall, 2010). Brazil et al., (2010) discussed palliation in the community setting and the issues that arose among different

healthcare professionals, including nurses, social workers, personal support workers, and speech language pathologists. These issues included appropriateness of care, incompetency of staff, lack of information, difficult discussions with family regarding expectations of care, and lack of appropriate resources (Brazil, et al., 2010). Nurse practitioners have the ability to address many of these issues, however, the complex dynamics between family and patient expectations, in addition to the lack of available resources, are barriers that these individuals may continue to endure as palliation continues to transition to the community (Brazil, et al., 2010).

"Policies" were described by participants as the difference in expectations among organizations and the professional body. Participants often expressed how the expectations opposed each other at times, and choosing which to abide by potentiated limitations in patient care. This theme appears unique to the current research literature. Nurse practitioners in the context of this study are in a unique position as their professional body is focused on protecting the public, while endorsing the practitioners, a process that appears to be in conflict with one another. Stahlke Wall (2017) noted a similar finding among advanced practice nurses in their expectation of their regulatory body as a "body that punishes", rather than one that supports the supports the practice and advancement of these clinicians. Registered nurses, however, do not appear to experience this conflict. Rather, the organizations and professional bodies that govern registered nurses appear to have aligning role expectations with the added presence of unions that are solely intended to support and protect its members. Interestingly, this issue is jurisdictionally dependent, as some provinces in Canada have both a regulatory body that protects the public, and a professional body that educates and supports the profession (College of Nurses of Ontario, 2017; Nurse Practitioner Association of Ontario, 2017).

In a response to their experiences of moral distress, nurse practitioners in this study identified methods used to address these issues. Many of these methods reflected personal practices, and included setting up boundaries, participating in activities that created an outlet to reduce stress, and communication with others to validate and support actions and decisions made. Interestingly, Laabs (2007) identified many of these methods as ways for nurse practitioners to reconcile their feelings regarding situations of moral distress. While Laabs (2007) depicted these as negative methods to counterbalance or neutralize their distress, participants in this study identified these methods as positive changes for their professional and personal lives.

An aim of this study was to advance understanding of moral distress as experienced by nurse practitioners in the continuing care setting. It is evident that nurse practitioners do experience moral distress on a regular basis. There are a variety of factors that contribute to their experiences of moral distress. However, it is evident that these factors are connected by one common thread, the nurse practitioner's desire to provide "good care" for patients, within the constraints of continuing care settings.

Limitations

This study had a few limitations. First, the sample contained only female participants. It is important that the sample be a diverse representation of the practicing population. However, results from gender diversity should not necessarily be expected to yield stereotypical results. Secondly, this study only included participants practicing in the community setting of continuing care. Further research to include individuals who practice in continuing care within facilities will provide additional information about nurse practitioner experiences with moral distress. Lastly, the term moral distress, although well defined in the literature, was interpreted differently by the

participants in this study. Although a standard definition was provided to potential participants prior to commencement of the initial meeting, the provision of a standard definition at the beginning of each interview may have aided participants in readily identifying experiences of moral distress.

Implications and Conclusion

Nurse practitioners can play a pivotal role in meeting the demands of the aging population in the Canadian healthcare system. Unfortunately, situations in practice have led to these individuals experiencing moral distress, a phenomenon that has been highly associated with negative outcomes. This study demonstrated that nurse practitioners experienced moral distress similarly to registered nurses. However, the contributing factors appeared to have a more pronounced impact, potentially related to the advanced level of practice independence and the persistent role issues in advanced practice. Results of this study identified five themes that contributed to nurse practitioner experience of moral distress: patients, perceptions, physicians, palliation, and policies. Although these themes appear discrete, they were reflective of barriers that participants encountered that impacted their overall ability to "do good" for the patient.

As researchers, we are only beginning to understand the experience of moral distress in the nurse practitioner population. It is imperative that future research be focused on gaining an increased understanding of moral distress in these individuals, to develop strategies that can address these experiences. Additionally, research should be focused on a variety of professions and practice settings to determine whether the experience of moral distress is limited to profession, practice setting, both, or neither. It is imperative that we continue to pursue research that will prevent these individuals from falling victim to the known outcomes of moral distress,

which have a profound impact on individual practitioners and, the strength of the overall healthcare system.

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Chapter 3

Discussion and Conclusion

Key Findings of the Study

This study has contributed to the understanding of the experience of moral distress of nurse practitioners in the continuing care setting. The data collected has provided a rich description of what experiences these individuals encounter, the factors that contribute to these experiences, and their responses to these situations. Participants discussed an overarching theme of wanting to "do good" for the patient, but faced many barriers that inhibited their ability to do so. From the six interviews that were completed, there were five main themes identified as contributing to the experience of moral distress. These themes were patients, perceptions, physicians, palliation, and policies.

Patients appeared to be a significant theme as it reflected the participants' struggle in provision of optimal care due to a variety of factors, including complexity of patient referrals and patient needs, restrictions in accessing necessary resources, and the expectation of their role to encompass a multitude of clerical duties. Participants spoke of their constant battle at an individual, systemic, and organizational level, which caused them to cope by either setting up boundaries for their own self-care, or deeming that their efforts were futile which caused them to "settle" with their given circumstances.

Perceptions focused on understandings that others had about the nurse practitioner role and scope of practice, including mainly family and managerial perspectives. Family perceptions described the encounters that the participants experienced where the family wishes and role of the nurse practitioner misalign in the presence of both stable and unstable patients. Managerial

perceptions included the lack of understanding of the nurse practitioner role, leading to a lack of support for the ethical dilemmas they experience, and delegation of inappropriate referrals.

The role of the *physician* as a contributor to the experience of moral distress is significant. Participants discussed the power struggle apparent between nurse practitioners and physician. Participants described the multiple ways that power was used over their practices, including physicians choosing not to communicate or collaborate on patient care, refusing to sign death certificates, and consulting nurse practitioners for inappropriate tasks.

Palliation as an area of tension comprised the situations that nurse practitioners encountered in attempting to meet the multiple demands of individuals that were engaged in palliative care. This included the patient, family, facility staff, and physicians. Additionally, the trend in healthcare to "treat in place" has not been full accepted by all nursing facilities, and has caused nurse practitioners to doubt the care that is being provided to both patient and family members.

Lastly, *policies* were described by participants as the misalignment in expectations set forth by the organization and the professional association. Participants expressed their struggle in determining which policies to uphold, and the inherent tensions as to which was the right choice. Additionally, participants spoke of how the professional body, the association that is responsible for governing the nurse practitioner profession, is also the collection that is responsible for protecting the general public. Participants spoke of the lack of support for them by their professional association and how, instead, many feared contact from them.

Implications for Clinical Practice

There is very little known regarding the experience of moral distress among nurse practitioners. This study contributes to our understanding of the factors that impact these

experiences. Palliative care is an area of practice that was identified in this study as an important area of focus when considering moral distress for nurse practitioners. Palliative care focuses on improving the quality of life of patients as well as their families during times of life-threatening illness, by preventing and alleviating symptoms of suffering through the use of interventions (World Health Organization, 2002). Unfortunately, as voiced by one participant, it is sometimes difficult to determine the line where palliative care transitions to medical assistance in dying (MAID). In Canada, the federal government has passed legislation that prevents physicians and nurse practitioners who participate in MAID from being charged under the criminal law (Government of Canada, 2017). As a result, the incidence of patients with "irremediable medical conditions" that are requesting MAID may increase (Government of Canada, 2017). Nurse practitioners are legally able to participate in MAID (Government of Canada, 2017). Decisions to participate, to acknowledge requests in this endeavor, and to determine the fine line between palliative care and MAID may be difficult situations that cause moral distress. It is imperative that research be focused in further understanding contributing factors as they pertain to nurse practitioners' experiences of moral distress in general and, more specifically, in the continuing care setting.

An additional area in which future research should be focused is on the impact of organizational leaders and the experience of moral distress. Research has demonstrated that individuals of power within the organization have the ability to affect the ethical climate (Humphries & Woods, 2016). Humphries & Woods (2016) contend that "moral distress does not occur in a vacuum; it is always the product of a negative ethical climate" (p. 272). It would seem that managers and leaders should be responsible for providing support when necessary, allowing time to debrief, and assisting in identifying solutions to ethical problems. However, the literature

has demonstrated a strong argument that nurses fear disclosure of ethical problems or voicing concerns due to fear of reprimand, incongruent competing priorities (e.g. organizational priorities versus professional goals), and misunderstandings due to managers from other disciplines (Humphries & Woods, 2016; Wall & Austin, 2008). Results of this study appear to uphold the latter argument, that nurse practitioners too practice within an unsupported negative ethical climate. Further research is needed to assess what role organizational leaders should play in addressing ethical concerns, and what methods best support a positive ethical climate.

Another avenue that also requires further research is on nurse practitioner-physician relationships. The entrenched medical model supports a hierarchal relationship in which physicians are viewed as superior to other healthcare professionals, including nurses (Burston & Tuckett, 2012). This model may change as nurse practitioners gain momentum in the healthcare system. Unfortunately, there are multiple factors that have prevented successful integration of nurse practitioners into the Canadian healthcare system (DiCenso, et al., 2010). These include funding models, unclear roles and scope of practice, and a lack of leadership support including physicians (DiCenso, et al., 2010). DiCenso et al., (2010) commented that interprofessional relationships among physicians and nurse practitioners are typically positive, however, there is a large body of literature that suggests otherwise. Laabs (2005) discussed that physicians feel threatened due to perceived competition among nurse practitioners for patients, a concept also discussed throughout this study. This perception may be inhibiting the ability of nurse practitioners to contribute to patient care and health system reform. Improvements in knowledge translation regarding nurse practitioner scope of practice and role to various key stakeholders, physicians included, may improve interdisciplinary relationships, as well as their integration into the healthcare system. Further research is needed to determine the general knowledge and

understanding regarding nurse practitioners' role and scope of practice, especially in the physician population.

Lastly, an interesting observation in this study pertained to the participants' ability to recall experiences of moral distress. Many participants did not know that they were experiencing moral distress on a regular basis. Each participant required significant probing to identify specific situations that caused them to experience moral distress. Some of this difficulty in identification may stem from a variety of reasons. Only one participant pondered the reason for her inability to recall these events, and attributed it to the possibility of not wanting to address the issue at the time, or that the heavy demands of the role in conjunction with the acuity of patients did not allow for self-reflection of ethical situations. Laabs (2005) posits that ethical issues are not always easily discernable and that in order to be able to identify these issues, individuals require an understanding of ethics. Further, Benner, Tanner, & Chesla (2009) also speculate that for excellence to be achieved as clinicians, it is imperative that these individuals must develop an expertise in ethical understanding. This area could be explored further in the future, to assess the effect that the ability to discern between morally distressing situations and the overall impact of the phenomenon on an individual.

Implications for Future Research

This study largely focused on the experience of moral distress of nurse practitioners in the continuing care setting. It is necessary that future research be directed, not only at the understanding the experience further, but also to identify strategies and tools to address these experiences. It may also be useful to focus on the understanding of the role and scope of practice of nurse practitioners as perceived by key stakeholders, such as physicians, nursing managers, other healthcare professionals, and the general population. By learning what is known and

perceived of this role, researchers can implement findings to aid the development of strategies to address moral distress. Lastly, future research should also aim to understand the experience of moral distress experienced by other healthcare professionals. This body of knowledge will assist in determining whether the overall healthcare system plays a significant role in the experience of moral distress as it spans multiple disciplines, or if these experiences are limited to the nursing profession and smaller sub-systems and encounters.

Limitations of the Study

There were a few limitations to this study. The sample was comprised of only female participants. Diversity is important as it assists in the development of rich descriptions of experiences, however, results from gender diversity would not be assumed to yield stereotypical results. This study also only included participants that practiced in the community setting of continuing care. The time limitations for this thesis project prevented further recruitment of individuals that practiced within facilities in continuing care. Further research should be extended to include these individuals, as it will provide additional information about nurse practitioner experiences with moral distress. The term moral distress, although well defined in the research literature, appeared to have a varied interpretation among participants. Although the definition was provided prior to commencement of the interviews, provision of the definition at the beginning of the interviews may have assisted participants in readily identifying experiences of moral distress.

Conclusion

The phenomenon of moral distress has been gaining the attention of researchers over the past 30 years. There is currently a substantive body of evidence demonstrating the negative effects of moral distress on healthcare professionals across the spectrum, with the bulk of the

research focusing on the general nursing population. Unfortunately, there continues to be a significant lack of research in the area pertaining to nurse practitioners. This study has contributed to our understanding of moral distress as experienced by nurse practitioners in the continuing care setting. This study demonstrated that the experience of moral distress for nurse practitioners is similar to that of registered nurses, although the contributing factors had perhaps a more pronounced impact because of the advanced level of independence and the persistent role issues in advanced practice. It is imperative that future research be focused on gaining an increased understanding of this experience in a variety of populations and practice settings, for the purpose of developing strategies for nurse practitioners, other health professionals, and organizational leaders to address these experiences. Canada's population is aging, causing an overall increase in stress on our healthcare system. Nurse practitioners working in the continuing care setting may play a pivotal role in assisting to alleviate this strain. It is necessary that we continue to pursue research that will prevent these individuals from falling victim to the known outcomes of moral distress, which have a profound impact on individual practitioners and, indeed, the strength of the healthcare system itself.

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Appendix A

Recruitment Letter

Dear Continuing Care Nurse Practitioner,

I am writing to tell you about the study "Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting" being conducted by a Master of Nursing student at the University of Alberta.

The purpose of this research study is to gain a better understanding of the experience of moral distress by nurse practitioners that practice in the continuing care setting.
You may be eligible for this study if you have been practicing as a nurse practitioner for more than 1 year, have practiced in the continuing care setting for more than 6 months, and have had an experience of moral distress.

If you are interested in learning more about this study, please complete the enclosed form, and mail it back to me in the pre-paid envelope. If you are not interested in the study, but are aware of others that may be, please feel free to forward on my contact information.

It is important to know that this letter is not to tell you to join this study. It is your decision. Your participation is voluntary. Whether or not you participate in this study will have no effect on your relationship with the University of Alberta.

Thank you for your time and consideration. I look forward to hearing from you.

Sincerely,

Vanessa Ritchie
Faculty of Nursing
University of Alberta
Email: vhang@ualberta.ca

Study Title: Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

Please complete this form and return in the pre-paid envelope provided

☐ I am interested in learning more about this study. Please contact me using the following information:

Name: _____
Telephone(s): _____
Best time and day to call: _____
Email: _____

Appendix B

Information Sheet and Consent Letter

Information Sheet and Consent Form for Nurse Practitioners in the Continuing Care Setting

Study Title: Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

Primary Researcher: Vanessa Ritchie
Faculty of Nursing
University of Alberta
E-mail: vhang@ualberta.ca

Research Supervisors: Dr. Tammy O'Rourke
Faculty of Nursing
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Part I: Information Sheet

Background

You are being asked to take part in this study as you are a nurse practitioner that practices within the continuing care setting. This Information & Consent Form is part of the process of informed consent. It explains this research study and what will happen if you choose to take part in this study. If you would like to know more about anything you read here, or have any questions at any time regarding this research study, please be sure to ask the researchers. Please read this form carefully to make sure you understand all the information provided. If there is any portion of the information sheet or consent form that you do not understand, please feel free to ask me any questions. You will receive a copy of this form to keep. Remember that your participation is entirely voluntary, and if you do not want to, you do not have to participate.

Purpose of the Research

Moral distress is a phenomenon that has recently emerged into the research literature. It is an experience in which an individual knows the right thing to do, but there are restrictions that prevent a certain act from happening. Much of the research regarding moral distress has been done in the field of nursing, with a very small portion being performed in the population of nurse practitioners. The purpose of this study is to gain a better understanding of the experience of moral distress of nurse practitioners that practice in the continuing care setting. With your assistance, we hope to better understand the implications that this phenomenon has on an individual at both a personal and professional level, as well as how they relate to previous findings of moral distress in the general nursing population. By gaining a better understanding, we may be able to contribute different approaches to improving the experience of moral distress. Findings of this study will be used for the researcher's graduate thesis work.

Procedure

If you agree to take part in this research study, you will be asked to meet with the researcher at a private place on a mutually agreed upon date and time between January 2017 and April 2017. You will partake in a face to face interview, lasting approximately 60 minutes in duration. These interviews will be audio-recorded, and the researcher may make notes. You will be asked questions about your experiences of moral distress, how they made you feel, and if there were any long term effects. If you were willing, there may be a second interview to ensure that the results obtained from the initial interview were what you intended, or to explore your experience further.

Participation and Withdrawal

Your participation in this study is entirely voluntary. You do not have to participate if you do not want to, and you are free to leave the study at any time, even following the signing of the consent letter. There is no impact to your practice if you choose not to participate in this study. You may also request that the information you provided be withdrawn from the study for a period of up to one month following the interview.

Risks

There are minimal risks to taking part in this study. It is possible that you may feel distressed or upset during the interview as talking about your experiences may be difficult. You are free to refuse to answer any questions during the interview or stop the interview at any time. There is no cost associated to you for this research study, other than your time which should not exceed an hour per interview, and with a second interview only occurring at request.

Benefits

The benefits of this research may affect you directly, as speaking about your experiences may be therapeutic. In addition, a greater understanding of the experience of moral distress may translate into future studies on the subject, as well as acknowledgement of needed approaches or solutions for the experience for individuals like yourself.

Confidentiality

Every effort will be made to keep confidential any information that is obtained during this research study. Information that is collected will not have your name on it. All reporting of the information

will be done in group format, so you will not be able to be identified. Direct quotes may be used, but your name and information will not be used. If there is any information collected during the study that could identify you, it will not be published in the results or told to anyone. Your identity will remain protected in any publications or presentations of the study results.

Information collected will be stored in a locked filing cabinet on the University of Alberta campus and on a secure place on a computer. Only the researcher will have access to this information.

Results of this study will be used in the researcher's thesis, presented at conferences, and published in research journals. As such, information collected may be stored for a period of up to 5 years. You may request that your data be destroyed at any time. If you are interested, you may also request a copy of the research findings in their completed state.

Right of Research Participants
You may withdraw your consent at any time during the study without consequences. If you have any questions or concerns about the research study, please feel free to contact the researcher at (780) 982-2612 or by email at vhang@ualberta.ca.

This study has been reviewed and received ethics clearance through the University of Alberta Research Ethics Board. If you have any questions regarding your rights as a participant, or how this study is being conducted, you may contact the University of Alberta's Research Ethics Office at (780) 492-2615. This office as no affiliation with the study investigators.

Contact Names and Telephone Numbers
Please contact the individual identified below at the time of consent and at any time during the study, if you have any questions or concerns about the research study and procedures:

Primary Researcher: Vanessa Ritchie
Faculty of Nursing
University of Alberta
vhang@ualberta.ca

Part II: Certificate of Consent

PARTICIPANT STATEMENT

I, _____, have been invited to take part in research regarding my experience with moral distress in the continuing care setting.

I have read the information sheet, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____
Signature of Participant _____
Date _____
Day/Month/Year

RESEARCHER STATEMENT

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the purpose and procedure of the research study.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.
Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/Month/Year

Appendix C

Consent for Future Contact

Study Title: Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

☐ You may contact me for further information regarding my responses given during the interview completed on (date)_____.

☐ Please contact me with the results of the study.

☐ Please remove my contact information from your files.

Print Name: _____
Signature: _____
Date: _____

Appendix D

Guiding Interview Questions

1. Tell me about your experiences of moral distress in the continuing care setting?
2. How did these experiences make you feel? What was your initial response?
3. Do you find yourself reflecting on these experiences often? In retrospect, how do these experiences make you feel?
4. What do you think are contributing factors that may have influenced these experiences?
5. Did you take any actions following the incident? If so, what were they? Was anyone else involved?
6. Do you feel that there were any short-term or long-term effects on you individually? On your practice?

Appendix E

Publishable Manuscript

Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

Abstract

Objective: To increase our understanding of moral distress experienced by nurse practitioners in the continuing care setting

Design: This qualitative study employed an interpretive description approach in which participants in a major urban center in Western Canada were interviewed about their experiences of moral distress.

Participants: The study consisted of a small sample of six nurse practitioners that practiced in the continuing care setting during the time of recruitment. Inclusion criteria ensured potential participants had practiced as a nurse practitioner for a minimum of one year, had practiced in the continuing care setting for a minimum of six months, and were able to speak English.

Methods: Semi-structured face-to-face interviews were conducted and recorded with each of the participants. Transcriptions were imported into QSR International NVivo Version 11 for thematic analysis of the participants' experiences of moral distress, including contributing factors, and methods to address these experiences.

Ethical Considerations: Ethical approval was obtained from the Research Ethics Board at the University of Alberta prior to commencement of the study.

Findings: This study provided confirmation that nurse practitioners in continuing care experience moral distress. The data presented five themes related to the tensions they identified in their descriptions of their experience. The themes were patients, perceptions, physicians, palliation, and policies. It was found that nurse practitioner experience of moral distress was similar to that of the registered nursing population, although the contributing factors had perhaps a more pronounced impact because of the advanced level of independence and the persistent role issues in advanced practice.

Conclusion: Moral distress is a substantial issue for nurse practitioner practice in the continuing care setting. Further research is required in the continuing care setting in addition to other settings, to determine as to whether the experience of moral distress is limited to the profession, practice setting, both, or neither. It is imperative that the experience and contributing factors of moral distress be addressed, and that strategies for cohesiveness among key stakeholders in continuing care be developed in order to decrease the negative experiences of nurse practitioners, and prevent them from leaving the profession.

Keywords: Moral distress, nurse practitioner, nursing, continuing care

Nurse Practitioners' Experiences of Moral Distress in the Continuing Care Setting

Introduction

This study explores the experiences of moral distress in nurse practitioners within the continuing care setting. The Canadian population is continuing to age, and as such, the strain on the healthcare system is increasing.[1] Nurse practitioners may play a fundamental role in alleviating some of this stress in their practice within the continuing care setting. Unfortunately, nurse practitioners are only now beginning to gain momentum in Canada, especially in the province of Alberta. As such, there is potential for these individuals to encounter situations related to a variety of contributing factors that may cause them to experience moral distress.

There is a notable lack of literature on moral distress in the nurse practitioner population with current research focusing largely on the general nursing population, specifically on registered nurses in a variety of acute care settings.[2,3,4] The aim of this study was to gain a better understanding of the experience of moral distress in the nurse practitioner population in the continuing care setting, as a means to understand the similarities and variances of experiences, as well as the contributing factors from that of the general nursing population. Nurse practitioners have the ability to influence individual and population health by increasing access to care, educating patients, and providing high quality care, specifically in chronic disease management.[5] By gaining a better understanding of their experience, we can gain insight into the factors that influence these experiences, potentially identifying solutions to alleviate moral distress. It is imperative that we gain this insight to reduce incidence of moral distress that this group of practitioners may be exposed to, and ideally prevent them succumbing to the currently known negative outcomes.

Background

The phenomenon of moral distress has been of increasing interest in the research literature over the past 30 years. Jameton[6] initially defined moral distress as when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Moral distress can occur both when initially exposed to a distressing situation, or can be more reactive, causing moral residue, when an individual is unable to act in such a situation.[7,8]

Moral distress has been studied across the spectrum of healthcare professionals. Until recently, much of the research performed was focused on registered nurses and their experiences within sensitive practice settings, which included intensive care units, mental health, and palliative care.[2,3,9,10] As a result of their experiences of moral distress, nurses have reported feeling angry, frustrated, powerless, anxious, helpless, embarrassed, and burnt out.[2,9,11-14] Further, many nurses have progressed to experiencing somatic symptoms such as heart palpitations, headaches, diarrhea, and insomnia.[13] The negative experiences of moral distress, coupled with increasing levels of moral residue have resulted in many nurses leaving their positions or leaving the nursing profession altogether.[2,9,11,14]

Nurse practitioners are registered nurses with advanced education, preparing them to provide comprehensive healthcare services to the community.[15] In Canada, nurse practitioners are

educated at a master's level, with a focus in the nursing model, and a foundation in comprehensive health.[5,16] The nursing model encompasses a comprehensive focus that includes both health and illness.[16] This model encourages the development of partnerships between clinician and individuals to ensure disease prevention, wellness, and optimal knowledge translation for the purpose of health education.[16] As advanced practice nurses, nurse practitioners have the legal authority and autonomy to "conduct comprehensive health [assessments], to diagnose health/illness conditions, [and to] treat and manage acute and chronic illness".[15] Nurse practitioners are also capable of ordering and interpreting diagnostic tests, performing certain procedures, and prescribing medications and therapeutic interventions.[5] Although nurse practitioners practice clinically using evidence-informed methods, they utilize a nursing approach, which places an emphasis on addressing patient needs and ensuring patient satisfaction through health promotion and holistic care.[5,17] The extensive knowledge and training achieved through education and experience allows nurse practitioners the ability to work both independently and collaboratively.[5]

Nurse practitioners may be ideal clinicians in the setting of continuing care. Continuing care is defined as a multitude of services that aim to support the health of individuals in a variety of community settings, including their own home, supportive living facilities, or in the long-term care setting.[18] In Canada, the population of individuals aged 65 and older is projected to increase from 4.2 million in 2005, to 9.8 million by 2036, with 1 in 3 individuals developing a disability.[19] This increase in individual needs will place an increased stress on the currently available continuing care services and resources. Utilization of nurse practitioners in the continuing care setting can assist in addressing both the acute and chronic needs of this population, as a means to assist in alleviating the overall strain on the healthcare system.

Purpose

The purpose of this study was to gain an understanding of nurse practitioners' experience of moral distress in the continuing care setting by addressing the following research questions: What are the experiences of moral distress of nurse practitioners in the continuing care setting? Specific sub-questions include: What factors contribute to continuing care nurse practitioners' experiences of moral distress? What issues need to be addressed to lessen the experiences of moral distress for nurse practitioners in continuing care?

Methodology

Study Design

The design utilized for this qualitative study was interpretive description. This method is ideal as it focuses on the generation of knowledge that is relevant to health disciplines.[20] Interpretive description aims to identify patterns and meaning in an experienced phenomenon that can assist in generating knowledge that may be directly utilized to impact healthcare practice.[20] Interpretive description stresses the importance of understanding the lived experience of individuals to best represent the phenomenon. In this study, the experience of nurse practitioners will be learned to better understand the phenomenon of moral distress as it exists in the continuing care setting.

Sample

The sample for this study was obtained through purposive sampling. Participants were recruited from various continuing care programs in a large urban setting in Western Canada. Inclusion criteria for this study included nurse practitioners that (1) had been practicing for a minimum of 1 year; (2) had been practicing in continuing care for a minimum of 6 months; (3) spoke English; (4) had had an experience of moral distress.

Ethical Considerations

Ethics approval was granted by the University of Alberta Research Ethics Board prior to commencement of this study. To maintain confidentiality of the participants, identification numbers have been assigned and will be used throughout the paper to preserve anonymity.

Data Collection

Data collection occurred during audio recorded face to face interviews. These interviews took place following initial contact, at a mutually agreed upon place and time. Interviews averaged an hour in duration and followed a semi-structured interview guide. The purpose of these interviews was to gain insight into nurse practitioners' experiences of moral distress, as well as acknowledge the factors that contributed to these experiences. The interview guide included both broad, open-ended questions such as, "Tell me about your experiences of moral distress?" and more specific questions including, "What impact did these experiences have on your practice?"

Data Analysis

Interpretive description data analysis is characterized by continued revisiting of data.[20] Superficial coding allowed for initial themes to be categorized and labelled; relationships among the themes were then identified.[20] Transcripts were reviewed following the interviews early on as timely exposure assisted in the development of new insights and questions, which were incorporated in future interviews. During further immersion in the data, memoing was used to code or sort the information in a manner consistent with my evolving analytical process. Transcribed interviews were imported into QSR International's NVivo version 11 software for thematic analysis. Grouping information in a thematic way permitted identification of relationships and patterns, which allowed for the development of theoretical concepts that may potentially lay the foundation for future change.[20]

Validity and Rigor

Interviews were transcribed through the aid of a third-party transcriptionist, who signed a confidentiality agreement. To ensure credibility of the data, the transcripts were read against the interview recordings to ensure a verbatim copy. The primary investigator conducted the initial review of the transcripts, in addition to the initial coding of the data. Coding was also completed by an additional member of the research team, with themes compared to ensure consensus of the interpretations. Additionally, member-checking was completed by providing the results back to

the participants to ensure that the interpretation and presentation of the data aligned with their original intent.

Results

All participants (n=6) were female nurse practitioners that were practicing in the continuing care setting during the time of recruitment. Their previous experience as registered nurses varied among practice settings and included home care, long-term care, emergency, rural, medicine, surgery, palliative care, and high-risk obstetrics. The mean age of the participants was 44, and the average length of nurse practitioner practice was 6.4 years with the range extending from 1.25 years to 15 years. Nurse practitioners in this study attended to patients living in a variety of continuing care settings. These settings included both facilities and private homes. They described the patients that they provided care for as often very complex, with needs that spanned the medical, psychological, and social spectrum. One participant described an example of this complexity in a continuing care patient who:

> "[has] chronic malnutrition…has a history of celiac and IBS…[and is] a heavy smoker…[She] lives alone [with] no support, [and] is in a relationship with a significant amount of domestic violence…She [also] suffers from a chronic history of depression [and] previous alcoholism." (P01).

In addition to complex patients, nurse practitioners in this study reported independent and collaborative work with a variety of other professionals, including physicians, nurses, and management teams.

All participants shared their experiences of moral distress in their careers as nurse practitioners in the continuing care setting. However, many of the participants were unaware that they were experiencing this phenomenon, and required significant probing during the interviews to identify these experiences. Probing was not used to guide individuals, rather the use of open-ended questions assisted them to reflect and identify specific experiences that they deemed as morally distressing. Five main themes pertaining to the various tensions that were evident in their experiences of moral distress were identified in the data analysis. The five themes are: patients, perceptions, physicians, palliation, and policies. Each of these themes will be described in detail in this section of the paper.

Figure 1

Table 1

Theme	Conceptual Definition
Patients	Tensions that arises from the nurse practitioner's desire to provide "good care" for their patients and constraints in providing this care due to the complexity of patient needs, accessibility to patient care resources.
Perceptions	Tensions that arise between the nurse practitioner and family members, as well as managers due to individual perceptions about the nurse practitioner role and scope of practice.
Physicians	Tensions that arise between nurse practitioners and physicians due to the presence of a "power struggle" between physicians and nurse practitioners as a result of the lack of respect for the nurse practitioner role.
Palliation	Tensions that arise for the nurse practitioner from the struggles to meet the multiple demands of the various individuals involved in palliative care and the lack of palliative care resources available.
Policies	Tensions that arise for the nurse practitioner due to a misalignment between organizational expectations and professional responsibilities of their role and the realities of practice, particularly time demands.

Patients

All participants spoke about their experiences of moral distress in relation to the pull between wanting to "do good" care for their patients and their ability to do so. Participants spoke about a variety of factors that inhibited their ability to do what they knew to be the "best care" for patients, including complexity of patient needs, restrictions in accessing diagnostic resources in a

community care setting, supplementary duties that took time away from patient care, and the hypervigilance required to ensure at least "safe patient care".

All six participants discussed patient complexity as a contributing factor to their experience of moral distress. They described patients as having multiple comorbid medical issues, in addition to psychological and social struggles. For example, one participant described a very complex situation involving a patient with a musculoskeletal injury that was compounded by various complications and unrelated co-morbidities such as a hematoma, skin disorders, infection, and swelling, pointing out that "[we] do all the interventions for people who can't access it elsewhere" (P01). The patients that the participants interacted with spanned the spectrum of stable to unstable, with the possibility always looming that their health status could change within minutes.

Participants discussed their ethical concern for providing evidence-based practice in an environment where they faced restrictions in accessing diagnostic resources. One participant talked about her limited ability to access urgent blood tests for a bedbound patient with limited family support, saying "You want stat blood work, good luck with that. Like it's not going to happen…No [one is going to] come from [the lab] until Monday next week, and you're on Tuesday" (P05). This participant described her distress in terms of feeling like "you're a slave to a system that's not designed for having home resources" (P05). Another participant described having "to work within those constraints" (P02) to provide care within very difficult situations. She described a complex patient care situation involving a bedridden bariatric patient requiring a chest x-ray, who could not leave his house nor afford a mobile x-ray. She reflected that "ideally, clinically I would want a whole bunch of investigations that could help guide me on the right path for management" (P02), although, in reality she did not have access to the necessary diagnostic resources.

Participants also described that, in their roles, they were often both clinician and support staff. In addition to their clinical responsibilities, participants talked about being responsible for ensuring that all clerical work was completed and that all parties that participated in patient care were made aware of new interventions and changes to the care plan. This work included ensuring that the most responsible practitioner, normally a physician, was aware of the changes, as well as pharmacies and case managers. As one NP participant explained,

> "Because the facilities are run independently, we need to ensure that the front-line staff delivering the care have the orders. We also need to…ensure that the [organizational] staff have the orders. We also need to ensure that any other physician who's involved or a primary care provider is aware. [They] also use community pharmacies…[There] are quite a few places that our documentation needs to go" (P02).

For these NPs, clerical responsibilities contributed to significant distress. They believed that taking time away from patient care to attend to clerical duties was an unethical constraint on their time and prevented them from providing the "best/safe care" for their patients, to the point that "[You] can sometimes feel like you're juggling about 10 balls in the air. Because you're dealing with so many people…[and] we're all over the zone. I'm so afraid of dropping a ball…to someone's detriment" (P04).

Perceptions

Many participants spoke of the tensions they experienced due to the individual perceptions of family members and managers about the nurse practitioner role and scope of practice. They discussed their turmoil during encounters with these individuals when their expectations did not align with the participants' intended plan of care, causing them to make ethical decisions regarding the correct course of action.

Participants discussed how family dynamics and perceptions of the nurse practitioner role have caused them to experience moral distress. Many encountered situations in which the expectation of the family members differed from that of the participant, causing them to question their own competency, and feeling torn in making ethical decisions regarding care. One participant described a situation in which the family member had questioned her clinical competency based on the family member's own anecdotal experience, causing her to feel "[stressed] that [you] may have treated [the patient] incorrectly" (P04). Another participant described a situation when family members expected care in the community to be the same as those in hospital. She explained that the family's expectation of her were significantly different than the services that she could offer. She reflected on the situation, pointing out "What can you do? Your heart hurts for them, because you know they're scared" (P05). Family perceptions caused the participant to experience moral distress, as she knew the limitations of her role in the community, but she felt compelled to do more to meet the needs of the family, a reality that could not be achieved within the constraints of her role.

Many participants also discussed the individual perceptions of managers regarding the nurse practitioner role and the tensions that arose when their expectations differed from that of the participant. Participants explained how the management teams that they reported to did not have an advanced practice nurse, but rather were comprised of various other professionals, including social workers, occupational therapists, and nurses. This lack of advanced nursing practice experience contributed to misunderstanding of the comprehensiveness of the care that was provided by participants. Participants verbalized their desire to engage with management regarding ethical situations and concerns they encountered in their daily work. However, previous futile attempts, in conjunction with a perceived lack of experience of patient care situations, caused participants to fear that their decisions would be perceived as unnecessary or unimportant, potentially exposing them to negative consequences. One participant stated, "We're trained to vocalize our concerns…and ask the hard questions and debate, but we're reprimanded for that…by our managers" (P04). Further, participants spoke of how management's perception of their role had led to inappropriate utilization of nurse practitioners, including "inappropriate referrals, or referrals for patients that [were] already being looked after by a physician" (P03). Participants experienced moral distress when having to decide whether they fulfil the obligations set out by their managers, or continue in their own practice to meet the needs of the patient. In response to these situations, one participant stated that they were often "flying under the radar" (P03) to ensure that they meet the needs of their patients while avoiding negative consequences.

Physicians

All participants spoke about their experiences of moral distress with wanting to be part of a collaborative team for the good of the patient, but tensions arose due to an apparent power struggle with physicians. Participants discussed a variety of situations where physicians appeared to manipulate patient circumstances to remain superior to the nurse practitioner. These situations included physicians ignoring communication from participants about mutual patients, physicians refusing to sign death certificates when not immediately involved in the patient's care, and a lack of respect for the nurse practitioner as demonstrated by inappropriate requests for patient services that did not require a nurse practitioner level of skill. All of these situations appeared to have caused the participants moral distress as these situations not only cause tension in an already "fragile relationship" (P05), but also limited their ability to provide "good" patient care.

Many participants discussed communication as a factor that contributed to their experience of moral distress. They spoke of how some physicians "[felt] a sense of ownership over their patient" (P01) and that they exhibit their power over nurse practitioners by choosing to forego communication. One participant discussed her frustrations and anger when nurse practitioners were "constantly having to be the one that is closing the gap" (P05) between themselves and physicians. She expressed her distress in that "[physicians] might take over and you might not know anything that they're doing…[and] you feel like you go to a great extent to have this communication relationship, and it's not reciprocated" (P05).

Participants also discussed restrictions in their practice and how the need to collaborate with physicians to ensure comprehensiveness of patient care was often a struggle. One participant spoke specifically about a situation in which "the family GP hadn't been engaged for a year and would not sign the death certificate" (P03). Additionally, another participant discussed her need to phone the physician prior to her interventions in patient care as a "courtesy" (P06), in the event that the patient passes away, as she too is unable to sign the death certificate. These situations caused participants to experience moral distress as they observed a seeming lack of patient and family centeredness, a focus on physician-centric practices, and their desire to exert power over the nurse practitioner through obstructing completion of patient care.

Participants also discussed the distress they experienced when tensions arose regarding physicians' lack of respect for the nurse practitioner role. Participants spoke of how physicians consulted and utilized nurse practitioners inappropriately and in a manner, that appeared to demean their role. One participant spoke of an interaction she experienced, when a physician requested that she provide an intravenous fluid bolus for a patient, which she perceived as belittling their scope of practice (P06). She discussed how "[a physician] wouldn't ask…another physician to do a bolus", and similarly should respect the role of nurse practitioners in the same manner. Participants spoke of their ethical struggle in encountering these interactions with physicians and the overall effect that it has on the forming of collegial relationships and ultimately, the impact on patient care.

Palliation

All participants spoke of the moral distress that they experienced during the provision of palliative care services to complex patient populations due to the tensions that arose in their inability to meet the needs of various key stakeholders. They spoke about their role in assisting

patients during their transition that ultimately allowed them to succumb to their comorbidities, and the ethical stress they experienced in knowing that the care they provide may be restricted due to their attempts to meet the needs of others that are present. Participants identified two specific factors that contributed to these situations of moral distress: their inability to meet the needs of all key stakeholders during dire situations, and the lack of provision of care by other healthcare professionals that have not accepted the idea of palliative care. Participants acknowledged that during these situations, they felt torn to make ethical decisions that appeased all individuals involved.

Situations of imminent death were seen as very morally distressing for participants. Participants spoke about the needs of multiple stakeholders in the patient's care. These stakeholders included family members, physicians, and other healthcare professionals. Participants discussed feeling torn about making the right decision when the varying needs of stakeholders countered one another. An example was described where,

> "[The patient] has a known reason for why her life is going to be ending. She's a [full code] at the time of the goals of care…She is…actively dying at the [same] time the physician is saying,… 'If the sister is not the legal guardian and even though she's listed, I want her to go to hospital.' Before [the patient] went unconscious, [she] had verbalized not wanting to go to hospital…So the moral distress of taking somebody's word, when they have dementia, because you know they're not cognitively well, and the exact same moral distress [in] having a sister that's grieving, who wants her to stay there, and you have a physician saying she can't. And…even just the moral distress of staff members looking at you for guidance, and I'm petrified." (P06).

Participants also discussed the lack of acceptance of other healthcare professionals to participate in palliative care in community settings. Some community living facility staff continue to hold the expectation that patients should go to hospital to die. One participant described how this lack of acceptance by facility staff caused her to "feel like I don't trust them when walking away…because I know that something is probably…not [going to] go well" (P05). Facility staff's unwillingness to participate in palliative care has also caused participants to feel torn in the way that they manage patient care, as they described the staff as "[seeing] you as a person who's going to come and write a bunch of orders that they don't want to do" (P05). These situations resulted in participants having to make ethical decisions regarding the type of interventions that they ordered to appease the staff, potentially at the cost of good patient care.

Policies

Many participants spoke of the tensions they experienced when organizational policy conflicted with the regulations set forth by their professional body. Participants discussed their feelings of turmoil when deciding which policies to uphold, as they could interfere in the degree of patient care that they could provide. Further, participants also discussed their ethical indecision in support for their professional regulatory body as the agenda of the association appeared to differ from that of participant expectations.

Participants discussed a feeling of disconnection between professional regulations and organizational policy and how these often countered one another. Participants discussed how

they had a professional obligation to perform in a certain way, but that the organization "puts different demands" on them (P02). An example of this was offered by a participant when she received diagnostic test results outside of her normal work hours, but knew that it was her "legal responsibility…[to respond] in a timely manner" (P01), as mandated by her professional association, especially since failure to do so could negatively impact the health of a patient. Further, she discussed that the concept of overtime was not supported by the organization, but was deemed a necessity to meet the obligations of the professional association. The misalignment between organizational and professional body contributed to participant experiences of moral distress as they were torn between which policies versus regulations to uphold in their practice.

Many of the participants also discussed the apprehension and the pull they experienced regarding loyalty to their professional association, as the expectations of participants and the agenda set forth by the professional association differ substantially. They discussed how, although they were expected to uphold regulatory policy, they struggled in their decision to do so at times, as they felt a lack of support as clinicians from the professional body. One participant discussed this conflict of interest in how their professional association was responsible for "[representing] and [protecting] the public" in addition to nurse practitioners and how "you can't have one body doing both" (P06). Further, the participant discussed the lack of social support by the professional body for the many difficult situations that nurse practitioners encounter on a regular basis (P06). She discussed her desire to engage with other nurse practitioners for validation and support through unauthorized social media, but feared the negative consequences she was faced with in doing so (P06). Participants struggled in maintaining loyalty to their professional association as they felt unsupported, and feared any potential contact.

Addressing Moral Distress

In addition to talking about the factors that contributed to moral distress, participants also shared strategies and personal methods to address moral distress. All participants discussed setting boundaries for themselves regarding their practice as a means of decreasing the effects of moral distress. These boundaries were meant to address the demands on their time and were set up as a mechanism to separate themselves from their professional work/self. Boundary setting was accomplished through the utilization of other available services for patients when they could predict their prognostic trajectories. Participants also engaged in self-care activities such as exercise and group activities and social activities with peers and family members that were not part of their normal work life.

Another method that all participants utilized to address their moral distress included discussions with their peers regarding specific patient situations. Participants described "[wanting to] know [that] you did the best you possibly could" (P03), and that this engagement allowed participants to gain validation for their actions. They referred to their team as their "lifeline" (P04) and explained that the support they received was substantial in gaining knowledge and acknowledging that they had done the right thing.

All of the participants spoke of strategies that assisted in alleviating some of their encounters of moral distress. A common strategy involved better communication with other key players in the

healthcare system regarding their role and scope of practice. They argued that a better understanding of their role in patient care could assist in ensuring that they were utilized appropriately and respected by those involved. One participant spoke at length about how "moral distress comes from both sides of the conversation not being known to everyone" (P06) and that increasing communication should extend to educating one another to ensure the best outcome for the patient.

Lastly, participants discussed the importance of their organization identifying the need to have an advanced practice nurse in the managerial role. They spoke about the importance of having someone who has experienced the situations they had encountered, as they could assist in navigating barriers with the participants. One participant had discussed the experience of having a previous manager who was an advanced practice nurse and explained how she really "pushed our practice and expanded our practice" (P04). She further spoke of how having a manager that understood the role and scope of practice of nurse practitioners was an asset in providing role clarity and ensuring proper utilization of these individuals in the healthcare system.

Discussion

This study has provided an important understanding of the experience of moral distress of nurse practitioners in the continuing care setting. The literature on moral distress is growing, with the majority of research focused on the general nursing population. This study contributes uniquely to what is already known about the experience of moral distress, providing a new view from the perspective of nurse practitioners. Analysis of the data revealed five themes that were found to contribute to participants' experiences of moral distress. The themes were patients, perceptions, physicians, palliation, and policies.

The initial theme of "patients" was described by participants to be specific constraints that the nurse practitioner experienced in attempting to provide "good" care. Participants spoke of the difficulty they encountered when providing care to complex patients, especially when they were faced with constraints that limited the availability of resources, and supplementary duties that restricted their time with patients and families. This finding is similar to two previous studies completed by Laabs[21,22] in which nurse practitioners providing care in primary care reported constraints in their attempts to provide "good" care. As an American study, these constraints were due to insurance coverage and their need to tailor treatment based on services covered.[21] Registered nurses experienced similar constraints related to workload, more specifically inadequate staffing levels and units working on an over-capacity basis, causing nurses to provide decreased quality of care.[4]

"Perceptions" was described by participants as individual perceptions of family members and managers of the nurse practitioner role and scope of practice. Participants spoke about the tensions experienced when their expectations for care and the expectations of family members did not align, especially during difficult situations. Laabs[21] discussed a similar finding in primary care where there were often discrepancies regarding code status and honoring patient wishes for patients during times of imminent change. Perceptions of managers regarding the nurse practitioner role and scope of practice was also an area in which many participants expressed their concern. They talked about the lack of support from these individuals, often due to a lack of

understanding regarding their role and the comprehensiveness of situations and patients encountered. Participants felt they were unable to discuss difficult situations with their mangers, as previous attempts to do so resulted in futility, or the perceived inappropriateness of interventions by their managers could extend to negative consequences. Similarly, registered nurses have also experienced the same issue with management on medical units.[10,23] Registered nurses reported feeling unsupported during difficult situations in which they experience moral distress, and have been silenced when speaking out about their concerns as these issues were transformed into a "disciplinary matter".[24]

The theme of "physicians" was discussed by all participants. The findings revealed that a significant power struggle was present between nurse practitioners and physicians, as demonstrated by their lack of respect for the nurse practitioner role and scope of practice. Unlike registered nurses, nurse practitioners have the ability to influence medical decisions that are made regarding patient care.[23] This change in scope of practice appeared to reject the previously present "hierarchal nature of the nurse/physician relationship" (p. 315).[3] Nurse practitioners have, in some way, leveled this hierarchy. However, this change has caused physicians to feel threatened and act out by manipulating patient circumstances.[17]

The theme "palliation" was discussed by participants as the distress experienced with patient care when death was imminent, and the tensions that arise when the demands of various stakeholders, including family members, physicians, and other facility staff, do not align. As palliation continues to transition to the community, incidence of patients dying outside of acute care facilities will increase.[25] Brazil et al.,[25] discussed palliation in the community setting and the issues that arose among different healthcare professionals, including nurses, social workers, personal support workers, and speech language pathologists. These issues included appropriateness of care, incompetency of staff, lack of information, difficult discussions with family regarding expectations of care, and lack of appropriate resources.[25] Nurse practitioners have the ability to address many of these issues, however, the complex dynamics between family and patient expectations, in addition to the lack of available resources, are barriers that these individuals may continue to endure as palliation continues to transition to the community.[25]

"Policies" were described by participants as the difference in expectations among organizations and the professional body. Participants often expressed how the expectations opposed each other at times, and choosing which to abide by potentiated limitations in patient care. This theme appears unique to the current research literature. Nurse practitioners in the context of this study are in a unique position as their professional body is focused on protecting the public, while endorsing the practitioners, a process that appears to be in conflict with one another. Stahlke Wall[26] noted a similar finding among advanced practice nurses in their expectation of their regulatory body as a "body that punishes", rather than one that supports the supports the practice and advancement of these clinicians. Registered nurses, however, do not appear to experience this conflict. Rather, the organizations and professional bodies that govern registered nurses appear to have aligning role expectations with the added presence of unions that are solely intended to support and protect its members. Interestingly, this issue is jurisdictionally dependent, as some provinces in Canada have both a regulatory body that protects the public, and a professional body that educates and supports the profession.[27,28]

In a response to their experiences of moral distress, nurse practitioners in this study identified methods used to address these issues. Many of these methods reflected personal practices, and included setting up boundaries, participating in activities that created an outlet to reduce stress, and communication with others to validate and support actions and decisions made. Interestingly, Laabs[22] identified many of these methods as ways for nurse practitioners to reconcile their feelings regarding situations of moral distress. While Laabs[22] depicted these as negative methods to counterbalance or neutralize their distress, participants in this study identified these methods as positive changes for their professional and personal lives.

An aim of this study was to advance understanding of moral distress as experienced by nurse practitioners in the continuing care setting. It is evident that nurse practitioners do experience moral distress on a regular basis. There are a variety of factors that contribute to their experiences of moral distress. However, it is evident that these factors are connected by one common thread, the nurse practitioner's desire to provide "good care" for patients, within the constraints of continuing care settings.

Limitations

This study had a few limitations. First, the sample contained only female participants. It is important that the sample be a diverse representation of the practicing population. However, results from gender diversity should not necessarily be expected to yield stereotypical results. Secondly, this study only included participants practicing in the community setting of continuing care. Further research to include individuals who practice in continuing care within facilities will provide additional information about nurse practitioner experiences with moral distress. Lastly, the term moral distress, although well defined in the literature, was interpreted differently by the participants in this study. Although a standard definition was provided to potential participants prior to commencement of the initial meeting, the provision of a standard definition at the beginning of each interview may have aided participants in readily identifying experiences of moral distress.

Implications and Conclusion

Nurse practitioners can play a pivotal role in meeting the demands of the aging population in the Canadian healthcare system. Unfortunately, situations in practice have led to these individuals experiencing moral distress, a phenomenon that has been highly associated with negative outcomes. This study demonstrated that nurse practitioners experienced moral distress similarly to registered nurses. However, the contributing factors appeared to have a more pronounced impact, potentially related to the advanced level of practice independence and the persistent role issues in advanced practice. Results of this study identified five themes that contributed to nurse practitioner experience of moral distress: patients, perceptions, physicians, palliation, and policies. Although these themes appear discrete, they were reflective of barriers that participants encountered that impacted their overall ability to "do good" for the patient.

As researchers, we are only beginning to understand the experience of moral distress in the nurse practitioner population. It is imperative that future research be focused on gaining an increased understanding of moral distress in these individuals, to develop strategies that can address these

experiences. Additionally, research should be focused on a variety of professions and practice settings to determine whether the experience of moral distress is limited to profession, practice setting, both, or neither. It is imperative that we continue to pursue research that will prevent these individuals from falling victim to the known outcomes of moral distress, which have a profound impact on individual practitioners and, the strength of the overall healthcare system.

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